

# Women With Disabilities Australia (WWDA)

Submission to the National Inquiry into Equal Recognition Before the  
Law and Legal Capacity for People With Disability

- January 2014 -

*Submission to the National Inquiry into Equal Recognition Before the Law and Legal Capacity for People With Disability*

By Carolyn Frohmader for Women With Disabilities Australia (WWDA)

© Women With Disabilities Australia (WWDA) January 2014

## About Women With Disabilities Australia (WWDA)

Women With Disabilities Australia (WWDA) is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA's work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the reproductive rights of women and girls with disabilities, along with promoting their rights to freedom from violence and exploitation, and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.

## Contact Details



Women With Disabilities Australia (WWDA)  
PO Box 605, Rosny Park 7018 TASMANIA, AUSTRALIA  
Ph: +61 3 62448288 Fax: +61 3 62448255  
Email: [carolyn@wwda.org.au](mailto:carolyn@wwda.org.au)  
Web: [www.wwda.org.au](http://www.wwda.org.au)  
Facebook: [www.facebook.com/WWDA.Australia](http://www.facebook.com/WWDA.Australia)  
Contact: Carolyn Frohmader, Executive Director

*Winner, National Human Rights Award 2001*  
*Winner, National Violence Prevention Award 1999*  
*Winner, Tasmanian Women's Safety Award 2008*  
*Certificate of Merit, Australian Crime & Violence Prevention Awards 2008*  
*Nominee, French Republic's Human Rights Prize 2003*  
*Nominee, UN Millennium Peace Prize for Women 2000*

# Contents

---

Introduction.....	5
Gendering the National Inquiry into Equal Recognition Before the Law & Legal Capacity for People With Disability.....	6
Sexual and Reproductive Rights and Freedoms .....	8
The Right to Freedom from Violence, Abuse, Exploitation and Neglect.....	19
The Right to Found and Maintain a Family .....	31
The Right to Work.....	35
The Right to Participate in Political and Public Life .....	38

## Supporting documents formally tabled with this Submission:

Frohman, C (2013) *'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia'* - WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia; ISBN: 978-0-9876035-0-0.

*DPP v Kumar* [20 November 2013] VCC.

Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia*. Background Paper. Hobart: Women with Disabilities Australia.

Women With Disabilities Australia (WWDA), University of New South Wales (UNSW), and People with Disabilities Australia (PWDA) (2013) *Report of the Proceedings and Outcomes of the National Symposium on Violence against Women and Girls with Disabilities*. Hobart: Women with Disabilities Australia.

Frohman, C (2011) *Women With Disabilities Australia (WWDA) Submission to the United Nations Thematic Study on Violence Against Women With Disabilities*. Hobart: Women with Disabilities Australia.

---

*'The Committee notes that the Australian Law Reform Commission has been recently commissioned to inquire into barriers to equal recognition before the law and legal capacity for persons with disabilities. The Committee is however concerned about the possibility of maintaining the regime of substitute decision-making, and that there is still no detailed and viable framework for supported decision-making in the exercise of legal capacity.'*

*The Committee recommends that the State party uses effectively the current inquiry process to take immediate steps to replace substitute decision-making with supported decision-making and provides a wide range of measures which respect the person's autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual's right, in his/her own capacity, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, and to work.*

*The Committee further recommends that the State party provides training, in consultation and cooperation with persons with disabilities and their representative organizations, at the national, regional and local levels for all actors, including civil servants, judges, and social workers, on the recognition of the legal capacity of persons with disabilities and on the primacy of supported decision-making mechanisms in the exercise of legal capacity.'*

Committee on the Rights of Persons with Disabilities  
Concluding observations on the initial report of Australia  
Adopted by the Committee at its tenth session (2–13 September 2013)  
4th October 2013  
UN Doc. CRPD/C/AUS/CO/1

---



## Introduction

---

1. The determination of capacity is inextricably linked to the exercise of the right to autonomy and self-determination. To make a finding of incapacity results in the restriction of one of the most fundamental rights enshrined in law, the right to autonomy.<sup>1</sup> Yet many women with disabilities throughout Australia are stripped of their legal capacity, due to stigma and discrimination, through judicial declaration of incompetency or merely by a third party's decision that the woman "lacks capacity" to make a decision.
2. 'Incapacity' is very often used as a valid justification for violations of the human rights and fundamental freedoms of women and girls with disabilities. However, the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) clearly mandates States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others and should be supported to exercise their legal capacity. This means that an individual's right to decision-making cannot be substituted by decision-making of a third party, but that each individual without exception has the right to receive the supports they need to make their own choices and to direct their own lives, whether in relation to medical treatment, family, parenthood and relationships, or living arrangements.<sup>2</sup>
3. The CRPD also requires respect for the evolving capacities of children (CRPD Art 3 and 7) and the provision of support for children with disabilities to express their views, and for these views to be given appropriate weight in the context of their age and maturity.
4. This Submission from Women With Disabilities Australia (WWDA) highlights six key priority areas for women with disabilities that are considered crucial in the context of the *National Inquiry into Equal Recognition Before The Law And Legal Capacity For People With Disability*. These six areas are:
  - Gendering the National Inquiry into Equal Recognition Before the Law and Legal Capacity for People With Disability
  - Sexual and Reproductive Rights and Freedoms
  - The Right to Freedom from Violence, Abuse, Exploitation and Neglect
  - The Right to Found and Maintain a Family
  - The Right to Work
  - The Right to Participate in Political and Public life

This Submission provides several case studies to illustrate these issues as they affect women with disabilities in the context of legal capacity and equal recognition before the law. The case studies provided are actual cases that have come to WWDA's attention during the past few years. For the purposes of confidentiality, the case studies have been de-identified.

---

<sup>1</sup> Law Reform Commission (Ireland) (2011) *Sexual Offences and Capacity to Consent. A Consultation Paper*. Law Reform Commission, Dublin.

<sup>2</sup> In Frohmader, C. (2013) *'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia'*. Women with Disabilities Australia (WWDA), Rosny Park, Australia. At: [http://www.wwda.org.au/WWDA\\_Sub\\_SenateInquiry\\_Sterilisation\\_March2013.pdf](http://www.wwda.org.au/WWDA_Sub_SenateInquiry_Sterilisation_March2013.pdf)

## Gendering the National Inquiry into Equal Recognition Before The Law And Legal Capacity For People With Disability

---

5. In recognition of the fact that women and girls with disabilities in Australia are subject to multiple discrimination and human rights violations, WWDA strongly encourages the ALRC to ensure that a gender analysis be employed in all aspects of the *National Inquiry into Equal Recognition Before The Law And Legal Capacity For People With Disability*. As a member State of the United Nations, and as a party to a number of human rights conventions and instruments which create obligations in relation to gender equality and to disability rights, Australia has committed to take all appropriate measures, including focused, gender-specific measures to ensure that women and girls with disabilities experience full and effective enjoyment of their human rights.<sup>3</sup> The CRPD for example, recognises gender as one of the most important categories of social organisation, emphasising the obligation of States Parties to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by people with disabilities. There is, therefore, a clear obligation on States Parties to recognise that the rights of women with disabilities must be addressed when interpreting and implementing every article of the CRPD.
6. Despite the CRPD's clear articulation of the obligation for a gendered perspective in all efforts to promote the human rights of disabled people, people with disabilities are often treated as asexual, genderless human beings. This view is borne out in disability policies and programs the world over, which consistently fail to apply a gender lens. Most proceed as though there are a common set of issues - and that men and women experience disability in the same way.<sup>4</sup> However women with disabilities and men with disabilities have different life experiences due to biological, psychological, economic, social, political and cultural attributes associated with being female and male. Patterns of disadvantage are often associated with the differences in the social position of women and men. These gendered differences are reflected in the life experiences of women with disabilities and men with disabilities. For example, women with disabilities:
  - experience violence, particularly family/domestic violence, violence in institutions, and violence in the workplace, more often than disabled men,<sup>5</sup> are often at greater risk than disabled men, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation;<sup>6</sup> and, are more vulnerable as victims of crimes from both strangers and people who are known to them;<sup>7</sup>
  - witness cases involving crimes against them often go unreported, and/or inadequately investigated, remain unsolved or result in minimal sentences;<sup>8</sup>
  - are often denied effective access to justice because violations of their rights are not taken seriously;
  - are more exposed to practices which qualify as torture or inhuman or degrading treatment<sup>9</sup> (such as forced or coerced sterilisation, forced abortion, forced contraception, gender based violence, chemical restraint, forced psychiatric interventions);
  - are more likely than disabled men to acquire a disability through gender-based violence;<sup>10</sup>
  - are much more likely than disabled men, to experience restrictions, negative treatment, and violations of their sexual and reproductive rights;<sup>11</sup>

---

<sup>3</sup> UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 24 January 2007, A/RES/61/106.

<sup>4</sup> Gray, G. (2010 draft) *By Women for Women, the Australian women's health movement and public policy*.

<sup>5</sup> Women With Disabilities Australia (WWDA) (2007b) *'Forgotten Sisters - A global review of violence against women with disabilities'*. WWDA Resource Manual on Violence Against Women With Disabilities. Published by WWDA, Tasmania, Australia; Meekosha, H. (2004) *Gender and Disability*. Entry for the Sage Encyclopaedia of Disability. Available on line at: <http://wwda.org.au/gendis2001.htm>.

<sup>6</sup> See Preamble [q] of UN General Assembly, *Convention on the Rights of Persons with Disabilities*; A/RES/61/106.

<sup>7</sup> Groce, N. (2006) *People with Disabilities*, in Social Justice and Public Health, Barry S. Levy & Victor Sidel (Eds), accessed online April 2011 at: [http://www.aidslex.org/site\\_documents/DB-0018E.pdf](http://www.aidslex.org/site_documents/DB-0018E.pdf)

<sup>8</sup> WWDA (2007b) OpCit; Healey, L., Howe, K., Humphreys, C., Jennings, C. & Julian, F. (2008) *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. Published by the Victorian Women with Disabilities Network Advocacy Information Service, Melbourne; French, P., Dardel, J., & Price-Kelly, S. (2010) *Rights denied: Towards a national policy agenda about abuse, neglect and exploitation of persons with cognitive impairment*, People with Disability Australia, Sydney.

<sup>9</sup> Committee of Ministers of the Council of Europe (2009) *Declaration: Making gender equality a reality*. 119<sup>th</sup> Session of the Committee of Ministers, Madrid, 12 May 2009.

<sup>10</sup> WWDA (2007b) Op Cit; Commonwealth of Australia (2009) *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.

- are more likely to be sole parents, to be living on their own, or in their parental family than disabled men,<sup>12</sup> are at higher risk of divorce than disabled men and often experience difficulty maintaining custody of their children post-divorce;<sup>13</sup>
- are up to ten times more likely than other parents to have a child removed from their care by authorities on the basis of the mother's disability, rather than any evidence of child neglect;<sup>14</sup>
- are poorer and more likely to be unemployed than men with disabilities,<sup>15</sup> less likely to be in the paid workforce than disabled men, and have lower incomes from employment than men with disabilities;<sup>16</sup>
- are more likely to experience gender biases in labour markets, and are more concentrated than disabled men in informal, subsistence and vulnerable employment;<sup>17</sup>
- share the burden of responsibility for unpaid work in the private and social spheres, including for example, cooking, cleaning, caring for children and relatives;<sup>18</sup>
- are more likely than disabled men, to be affected by the lack of affordable housing, due to the major gap in overall economic security across the life-cycle, and to their experience of gender-based violence which leads to housing vulnerability, including homelessness;<sup>19</sup>
- are less likely to receive service support than disabled men;<sup>20</sup>
- face barriers in accessing adequate maternal and related health care and other services for both themselves and their child/ren,<sup>21</sup> and are more likely than disabled men to face medical interventions to control their fertility;<sup>22</sup>
- experience more extreme social categorisation than disabled men, being more likely to be seen either as hypersexual and uncontrollable, or de-sexualised and inert;<sup>23</sup>
- are more likely than disabled men to be portrayed in all forms of media as unattractive, asexual and outside the societal ascribed norms of 'beauty';<sup>24</sup>
- have significantly lower levels of participation in governance and decision making at all levels compared to men with disabilities;<sup>25</sup>
- from ethnic or indigenous communities are more likely to have to contend with forces that exclude them on the basis of gender as well as disability, culture and heritage.<sup>26</sup>

<sup>11</sup> Manjoo, Rashida (2012) Report of the Special Rapporteur on violence against women, its causes and consequences; UN General Assembly; UN Doc. A/67/227; Grover, A. (2011) *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. United Nations General Assembly; UN Doc. A/66/254.

<sup>12</sup> Meekosha, H. (2004) Op Cit.

<sup>13</sup> Arnade, S. & Haefner, S. (2006) *Gendering the Draft Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*. Legal background paper. Published by Disabled Peoples' International (DPI), Berlin.

<sup>14</sup> This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child's extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/>

<sup>15</sup> WWDA (2009) *Submission to the National Human Rights Consultation*. WWDA, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm>; Meekosha, H. (2004) Op Cit.

<sup>16</sup> WWDA (2008) *Submission to the Parliamentary Inquiry into pay equity and associated issues related to increasing female participation in the workforce*. WWDA, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm>; Human Rights and Equal Opportunity Commission (HREOC), 2005, *National Inquiry into Employment and Disability*; Issues Paper 1: Employment and Disability - The Statistics; HREOC, Sydney; O'Reilly, A. (2007) *The right to decent work of persons with disabilities*. International Labour Office (ILO), Geneva; Arnade, S. & Haefner, S. (2006) Op Cit.

<sup>17</sup> UN Development Fund for Women (UNIFEM) (2008) *Progress of the World's Women 2008/2009: Who Answers to Women? Gender & Accountability*. Available at: <http://www.unhcr.org/refworld/docid/4a09773a2.html> [accessed 2 August 2009]

<sup>18</sup> Cited in: Australian Human Rights Commission (2010), Op Cit.

<sup>19</sup> Australian Human Rights Commission (2010) *Australia's Implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*. Independent Report to the Committee on the Elimination of Discrimination against Women. Accessed online July 2010 at: <http://www2.ohchr.org/english/bodies/cedaw/cedaws46.htm>

<sup>20</sup> See: Australian Institute of Health & Welfare (AIHW) (2009) *Disability support services 2007 – 08*. National data on services provided under the Commonwealth State/Territory Disability Agreement. Disability series. Cat. no. DIS 56. Canberra: AIHW; Arnade, S. & Haefner, S. (2006) Op Cit.

<sup>21</sup> World Health Organization (2009) *Promoting sexual and reproductive health for persons with disabilities*, WHO/UNFPA Guidance Note 2009, accessed on line April 2011 at: [http://whqlibdoc.who.int/publications/2009/9789241598682\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241598682_eng.pdf)

<sup>22</sup> Brady, S., Briton, J. & Grover, S. (2001) *The Sterilisation of Girls and Young Women in Australia: Issues and Progress*. A report commissioned by the Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner; Human Rights and Equal Opportunity Commission, Sydney, Australia. Available online at <http://www.wwda.org.au/brady2.htm>; WWDA (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*. WWDA, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm>; Steele, L. (2008) Making sense of the Family Court's decisions on the non-therapeutic sterilisation of girls with intellectual disability; *Australian Journal of Family Law*, Vol.22, No.1.

<sup>23</sup> Meekosha, H. (2004) Op Cit.

<sup>24</sup> Ortoleva, S. (2011) *Recommendations for Action to Advance the Rights of Women and Girls with Disabilities in the United Nations system*; accessed online April 2011 at: <http://sites.google.com/site/womenenabled/>

<sup>25</sup> United Nations Development Programme (UNDP) (2010) *Political Participation of Women with Disabilities in Cambodia: Research Report 2010*, accessed online April 2011 at: <http://www.un.org.kh/undp/knowledge/publications/political-participation-of-women-with-disabilities-in-cambodia>

## Sexual and Reproductive Rights and Freedoms

---

7. No group has ever been as severely restricted, or negatively treated, in respect of their sexual and reproductive rights, as women with disabilities.<sup>27</sup> The CRPD Committee has clearly identified that discrimination against women and girls with disabilities in areas of sexual and reproductive rights, including gender-based violence, is in clear violation of multiple provisions of the CRPD. The CRPD Committee has also explicitly articulated the urgent need for States Parties to address these multiple violations.<sup>28</sup>
8. Sexual and reproductive rights are fundamental human rights. They embrace human rights that are already recognised in international, regional and national legal frameworks, standards and agreements.<sup>29</sup> They include the right to bodily integrity, autonomy and self-determination – the right of everyone to make free and informed decisions and have full control over their body, sexuality, health, relationships, and if, when and with whom to partner, marry and have children – without any form of discrimination, stigma, coercion or violence. This includes the right of everyone to experience, enjoy and express their sexuality, to be free from interference in making personal decisions about sexuality and reproductive matters, the right to experience love, intimacy, sexual identity and the right to access sexual and reproductive health information, education, services and support. It also includes the right to be free from torture and from cruel, inhumane or degrading treatment or punishment; and to be free from violence, abuse, exploitation and neglect.<sup>30</sup>
9. However, women and girls with disabilities in Australia have failed to be afforded, or benefit from, these provisions in international, regional and national legal frameworks, standards and agreements – many of which Australia is a party to. Instead, systemic prejudice and discrimination against women and girls with disabilities continues to result in multiple and extreme violations of their sexual and reproductive rights, through practices such as forced and/or coerced sterilisation, forced contraception and/or limited or no contraceptive choices, a focus on menstrual and sexual suppression, poorly managed pregnancy and birth, forced or coerced abortion, termination of parental rights, denial of/or forced marriage, and other forms of torture and violence, including gender-based violence. They also experience systemic exclusion from sexual and reproductive health care services, information and education. These practices and violations are framed within traditional social attitudes and entrenched disability-based and gender-based stereotypes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.<sup>31</sup>

---

<sup>26</sup> Groce, N. (2006), Op Cit.

<sup>27</sup> Manjoo, Rashida (2012) OpCit.

<sup>28</sup> See for eg: Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain*. UN Doc. No: CRPD/C/ESP/CO/1; 19 October 2011; Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Peru*. UN Doc. No: CRPD/C/PER/CO/1; 9 May 2012; Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: China*. UN Doc. No: CRPD/C/CHN/CO/1; 27 September 2012; Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Hungary*. UN Doc. No: CRPD/C/HUN/CO/1; 27 September 2012; Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia*. UN Doc. No: CRPD/C/TUN/CO/1; 13 May 2011.

<sup>29</sup> High-Level Task Force for the ICPD (2013) *Policy Recommendations for the ICPD Beyond 2014: Sexual and Reproductive Health & Rights for All*. <http://www.icpdtaskforce.org/pdf/Beyond-2014/policy-recommendations-for-the-ICPD-beyond-2014.pdf>

<sup>30</sup> Ibid.

<sup>31</sup> Frohmader, C. (2013) 'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia'; OpCit. See also: Ortoleva, S. & Lewis, H. (2012) 'Forgotten Sisters- A Report on Violence Against Women with Disabilities: An Overview of its Nature, Scope, Causes and Consequences'; Northeastern University School of Law Research Paper No. 104-2012. At: <http://ssrn.com/abstract=2133332>



## Forced and coerced sterilisation

10. Women and girls with disabilities in Australia are at particular risk of forced and coerced sterilisations performed under the auspices of legitimate medical care or the consent of others in their name.<sup>32</sup> Forced sterilisation<sup>33</sup> of women and girls with disabilities is a practice that remains legal and sanctioned by Governments in Australia, yet represents grave violations of multiple human rights and breaches every international human rights treaty to which Australia is a party.<sup>34</sup> Forced sterilisation is an act of violence,<sup>35</sup> a form of social control, and a clear and documented violation of the right to be free from torture.<sup>36</sup> Perpetrators<sup>37</sup> are seldom held accountable and women and girls with disabilities who have experienced this violent abuse of their rights are rarely, if ever, able to obtain justice.<sup>38</sup>
11. The monitoring bodies of the core international human rights treaties<sup>39</sup> have all found that forced/involuntary and coerced sterilisation clearly breaches multiple provisions of the respective treaties.<sup>40</sup>
12. Since 2005, the United Nations treaty monitoring bodies have consistently and formally recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their prior, fully informed and free consent.<sup>41</sup>
13. In October 2013, the Committee on the Rights of Persons with Disabilities released its *Concluding Observations [Australia]* following its September 2013 review of Australia's compliance with the CRPD. The Committee expressed its "deep concern" with the recommendations of the Australian *Senate Inquiry Report into the Involuntary or Coerced Sterilisation of Persons with Disabilities*, (released in July 2013), which would allow the practice of involuntary/forced sterilisation to continue. The Committee also expressed its "regret" regarding the failure of Australia to implement the recommendations from the Committee on the Rights of the Child (CRC/C/15/Add.268; CRC/C/AUS/CO/4), the Human Rights Council (A/HRC/17/10), and the

<sup>32</sup> Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA) (2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper*. Available at:

[http://www.wwda.org.au/Sterilization\\_Disability\\_Briefing\\_Paper\\_October2011.pdf](http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf). See also: International Federation of Gynecology and Obstetrics (2011) *Female Contraceptive Sterilization*. Available at: <http://www.wwda.org.au/FIGOGuidelines2011.pdf>

<sup>33</sup> 'Forced/involuntary sterilisation' refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure, including instances in which sterilisation has been authorised by a third party, without that individual's consent. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to life. Coerced sterilisation occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent. Any sterilisation of a child, unless performed as a life-saving measure, is considered a forced sterilisation.

<sup>34</sup> Centre for Reproductive Rights, European Disability Forum, InterRights, International Disability Alliance and the Mental Disability Advocacy Centre (2011) *Written Comments Submitted in the European Court of Human Rights: Joelle Gauer and Others [Applicant] Against France [Respondent]*, 16 August 2011. See also: Méndez, Juan. E., (2013) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN General Assembly; UN.Doc A/HRC/22/53.

<sup>35</sup> See: Manjoo, Rashida (2012) OpCit. See also: Radhika Coomaraswamy (1999), *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences: Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, (55th Sess.), E/CN.4/1999/68/Add.4 (1999), [para. 51].

<sup>36</sup> Méndez, Juan. E., (2013) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN General Assembly; UN.Doc A/HRC/22/53; See also: Nowak, M. (2008) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*; UN General Assembly, UN Doc. A/HRC/7/3; Committee on the Rights of the Child (2011) *General Comment No. 13: Article 19: The right of the child to freedom from all forms of violence*; UN Doc. CRC/C/GC/13.

<sup>37</sup> A State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres. As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors. See: Méndez, Juan. E., (2013) UN.Doc A/HRC/22/53.

<sup>38</sup> Frohmader, C. (2013) OpCit.

<sup>39</sup> OHCHR, The Core International Human Rights Instruments and their monitoring bodies. See:

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx>

<sup>40</sup> Frohmader, C. (2013) OpCit.

<sup>41</sup> Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention; *Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).

Report of the UN Special Rapporteur on Torture (A/HRC/22/53), which addresses concerns regarding sterilisation of children and adults with disabilities. The CRPD Committee subsequently:

*“urges the State party to adopt national uniform legislation prohibiting the use of sterilisation of boys and girls with disabilities, and of adults with disability in the absence of their prior, fully informed and free consent.”<sup>42</sup>*

14. In June 2012, the Committee on the Rights of the Child (CRC), in its *Concluding Observations*<sup>43</sup> to the Fourth periodic report of Australia,<sup>44</sup> expressed its serious concern that the absence of legislation prohibiting non-therapeutic sterilisation of girls and women with disabilities “is discriminatory and in contravention of article 23(c) of the Convention on the Rights of Persons with Disabilities.....”. The Committee urged the State party to:

*‘Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities.’*

Furthermore, the CRC Committee clearly identified non-therapeutic sterilisation as a form of violence against girls and women, and recommended that the Australian Government:

*‘develop and enforce strict guidelines to prevent the sterilisation of women and girls who are affected by disabilities and are unable to consent.’*

15. In January 2011, in follow-up to Australia’s *Universal Periodic Review*,<sup>45</sup> the UN Human Rights Council endorsed a recommendation specifically addressing the issue of sterilisation of girls and women with disabilities. It specified that the Australian Government should enact national legislation prohibiting the use of non-therapeutic sterilisation of children, regardless of whether they have a disability, and of adults with disabilities without their informed and free consent.<sup>46</sup> The Australian Government’s formal response to this recommendation illustrated an apathy and indifference to the urgency of the issue, and a callous disregard of the human rights of women and girls with disabilities, including the right of women and girls with disabilities to retain their fertility on an equal basis as others. The Australian Government’s formal response stated:

*‘The Australian Government will work with states and territories to clarify and improve laws and practices governing the sterilisation of women and girls with disability.’<sup>47</sup>*

16. However, the human rights treaty monitoring bodies have made it clear that the issue of involuntary/forced/non-therapeutic cannot be left as a matter for State and Territory Governments to regulate, but rather, requires national leadership and a national response.<sup>48</sup>

---

<sup>42</sup> Committee on the Rights of Persons with Disabilities; Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (2–13 September 2013); 4<sup>th</sup> October 2013, UN Doc. CRPD/C/AUS/CO/1

<sup>43</sup> Committee on the Rights of the Child; UN Doc. CRC/C/AUS/CO/4.

<sup>44</sup> Committee on the Rights of the Child; UN Doc. CRC/C/AUS/4.

<sup>45</sup> The Universal Periodic Review (UPR) is a process undertaken by the United Nations and involves the review of the human rights records of the 192 Member States once every four years. The UPR provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations. The ultimate aim of the Review is to improve the human rights situation in all countries and address human rights violations wherever they occur. For more information see:

<http://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>

<sup>46</sup> UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10;

<sup>47</sup> On 10 December 2012, International Human Rights Day, the Australian Government released its National Human Rights Action Plan. In releasing the Plan, the then Federal Attorney General, Hon Nicola Roxon MP, stated that: ‘This action plan explains in detail how Australia will implement the recommendations accepted during its Universal Periodic Review at the United Nations in 2011.’ See for eg: Commonwealth of Australia (2012) *Australia’s National Human Rights Action Plan 2012*. Accessed online 10/12/2012 at: <http://www.ag.gov.au/Humanrightsandantidiscrimination/Australiahumanrightsframework/Pages/NationalHumanRightsActionPlan.aspx> See also: Hon Nicola Roxon MP, Attorney-General & Minister for Emergency Management, Media Release ‘National Human Rights Action Plan Released’, 10/12/12.

<sup>48</sup> Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7;

17. In July 2010, at its 46<sup>th</sup> session, the UN Committee on the Elimination of Discrimination against Women (CEDAW) expressed concern in its *Concluding Observations on Australia* at the ongoing practice of non-therapeutic sterilisations of women and girls with disabilities and recommended that the Australian Government:

*‘enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.’*<sup>49</sup>

18. In 2005, the Committee on the Rights of the Child in considering Australia’s combined second and third periodic reports<sup>50</sup> under Article 44 of the *Convention on the Rights of the Child* (CRC), recommended that *‘the State party.....prohibit the sterilization of children, with or without disabilities.....’*<sup>51</sup> and in 2007 clearly articulated its position on sterilisation of girls with disabilities, clarifying that States parties to the CRC are expected to prohibit by law the forced sterilisation of children with disabilities.<sup>52</sup>

19. Australia is due to report to the United Nations Human Rights Committee on Australia’s compliance with the *International Covenant on Civil and Political Rights* (ICCPR), and is scheduled to appear for review by the Human Rights Committee in 2014. Under the heading of *‘Violence Against Women’*, the List of Issues Prior to Reporting (LOIPR),<sup>53</sup> (adopted by the Human Rights Committee at its 106<sup>th</sup> session in late 2012) for Australia contains a question on sterilisation, to which the Australian Government will be expected to respond.<sup>54</sup> Specifically, it states:

*Please provide information on whether sterilization of women and girls, including those with disabilities, without their informed and free consent, continues to be practiced, and on steps taken to adopt legislation prohibiting such sterilisations.*

20. International medical bodies, such as the *International Federation of Gynecology & Obstetrics* (FIGO), have also now developed new protocols and calls for action to put an end to the practice of forced sterilisation, shoring up informed consent protocols and clearly delineating the ethical obligations of health practitioners to ensure that women, and they alone, are giving their voluntary and informed consent to undergo a surgical sterilisation.<sup>55</sup> The FIGO *‘Guidelines on Female Contraceptive Sterilization’* clearly state that:

*‘It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.’*

21. In calling for an end to the practice of forced sterilisation of women and girls with disabilities, human rights treaty monitoring bodies, international medical bodies, human rights advocates and disability advocates also recognise that adult women with disabilities have the same rights as their non-disabled counterparts to *choose* sterilisation as a means of contraception. In this

<sup>49</sup> UN Doc. CEDAW/C/AUS/CO/7, Op Cit.

<sup>50</sup> UN Convention on the Rights of the Child (CRC)(2004) *Consideration of Reports Submitted By States Parties Under Article 44 of the Convention; Second and third periodic reports of States parties due in 1998 and 2003:Australia*; 29 December 2004; CRC/C/129/Add.4.

<sup>51</sup> Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).

<sup>52</sup> CRC General Comment No.9 [at para.60] states: *‘The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.’* See: Committee on the Rights of the Child (CRC), *General Comment No. 9* (2006): *The rights of children with disabilities*, 27 February 2007, UN Doc.CRC/C/GC/9.

<sup>53</sup> Since Australia was last reviewed in 2009, the Human Rights Committee has developed a new optional process for the review of states, known as the List of Issues Prior to Reporting (LOIPR). The Human Rights Committee develops a LOIPR on the basis of previous Concluding Observations and information provided by the Office of the High Commissioner on Human Rights (OHCHR), the Universal Periodic Review (UPR), the UN Special Procedures, NGOs and National Human Rights Institutions. The LOIPR on Australia was adopted by the Human Rights Committee at its 106<sup>th</sup> session in late 2012.

<sup>54</sup> Human Rights Committee, *International Covenant on Civil and Political Rights; List of issues prior to the submission of the sixth periodic report of Australia* (CCPR/C/AUS/6), adopted by the Committee at its 106<sup>th</sup> session (15 October–2 November 2012); UN Doc No. CCPR/C/AUS/Q/6; 9 November 2012.

<sup>55</sup> International Federation of Gynecology and Obstetrics (2011) OpCit.

context, safeguards to prevent forced sterilisation should not infringe the rights of women with disabilities to choose sterilisation voluntarily and be provided with all necessary supports to ensure that they can make and communicate such a choice based on their free and informed consent.<sup>56</sup>

22. In September 2012 the Australian Senate commenced an *Inquiry into the Involuntary or Coerced Sterilisation of People with Disability in Australia*, and released the Inquiry Report in July 2013.<sup>57</sup> The Senate Committee undertaking the Inquiry worked hard to ensure that people with disabilities, particularly women with disabilities, were able to participate in the Inquiry and express their views. However, as it transpired, the views of women with disabilities – those most affected by forced sterilisation and other denials of reproductive rights – held little weight and had less influence than the views of parents, carers, guardians and a myriad of ‘professionals’ and other ‘experts’, many of whom argued for the practice of sterilisation of girls and women with disabilities to be allowed to continue in Australia.<sup>58</sup>
23. Although several of the Inquiry Report’s recommendations were welcomed and long overdue – particularly those emphasising the need for reproductive and sexual health education, training and support for people with disability, the medical workforce, judicial and legal officers – the Inquiry Report recommends that national uniform legislation be developed to regulate sterilisation of children and adults with disabilities, rather than to prohibit the practice, as has long been recommended to Australia by international human rights treaty bodies, UN special procedures, human rights advocates, disability advocates, and most importantly women with disabilities themselves.
24. The Senate Inquiry Report recommends that for an adult with disability who has the ‘capacity’ to consent, sterilisation should be banned unless undertaken with that consent. However, based on Australia’s Interpretative Declaration in respect of Article 12, the Report also recommends that where a person with disability does not have ‘capacity’ for consent, substitute decision-making laws and procedures may permit the sterilisation of persons with disability. The Report further recommends that the financial costs incurred by parents or guardians in child sterilisation cases be covered by legal aid, which could in fact; make it easier rather than more difficult, for sterilisation procedures to be sought.
25. It is clear that Australia’s Interpretative Declaration to the CRPD (in respect of Articles 12, 17) has in fact exacerbated the pervasive violations of the human rights of disabled women and girls, and been used by successive Australian Government as a justification to deny disabled women and girls their sexual and reproductive rights. Regardless of the fact that the monitoring bodies of the core international human rights treaties<sup>59</sup> have all found that forced/involuntary and coerced sterilisation clearly breaches multiple provisions of the respective treaties,<sup>60</sup> the Australian Government has determined that Australia’s obligations are shaped by the Interpretative Declarations made at the time Australia *entered into* the Convention. In entering to the treaty, Australia declared its view that the CRPD allows for substituted decision-making and compulsory medical treatment.
26. During its September 2013 review of Australia’s compliance with the CRPD, the CRPD Committee, repeatedly expressed its concern at the impact of Australia’s Interpretative Declarations to articles 12, 17 and 18 on the implementation of the CRPD. The CRPD Committee stressed to the Australian Government delegation, that these Interpretive Declarations have in fact hindered Australia’s ability to comply with the *Convention on the Rights of Persons with Disabilities* (CRPD). The Committee repeatedly asked the Government delegation what actions would be taken to repeal these Interpretative Declarations. In responding to these concerns, Mr Peter Woolcott (Australian Ambassador to the Permanent Mission to the UN), speaking on behalf of the Australian Government delegation, advised the CRPD Committee that due to ‘caretaker mode’ the

<sup>56</sup> WWDA, Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA) (2011) OpCit.

<sup>57</sup> Community Affairs References Committee, *Involuntary or coerced sterilisation of people with disabilities in Australia*. July 2013, Available at: [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate\\_Committees?url=clac\\_ctte/involuntary\\_sterilisation/first\\_report/index.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/involuntary_sterilisation/first_report/index.htm)

<sup>58</sup> See the Senate Inquiry Submissions online at:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Involuntary\\_Sterilisation/Submissions](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/Submissions)

<sup>59</sup> OHCHR, The Core International Human Rights Instruments and their monitoring bodies, OpCit.

<sup>60</sup> In Frohmader, C. (2013) OpCit.



delegation was unable to provide a response to the issue of the Interpretive Declarations, as this “would be a matter for any new incoming federal Government after the election.” However, he did state that he was “unaware of any intention for the Australian Government to repeal its Interpretive Declarations to the CRPD.”<sup>61</sup>

27. The Report of the *Senate Inquiry into Involuntary Sterilisation of People with Disabilities in Australia*, used Australia’s Interpretative Declaration to the CRPD to reject the United Nations (and WWDA’s) recommendation that the Australian Government ‘enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their prior, fully informed and free consent.’ Instead, the Senate Inquiry Report stipulated that:

*In those cases where there is not capacity for consent, and no reasonable prospect that it may develop, laws and procedures may permit the sterilisation of persons with disabilities, but the circumstances in which this may occur must be narrowly circumscribed, and based on the protection and advancement of the rights of the person.*<sup>62</sup>

28. In early 2013, the UN Special Rapporteur on Torture [and other cruel, inhuman or degrading treatment or punishment], in addressing reproductive rights violations under the torture framework,<sup>63</sup> clarified that forced sterilisation of people with disabilities, regardless of whether the practice is legitimised under national laws or justified by theories of incapacity and therapeutic necessity, violates the absolute prohibition of torture and cruel, inhuman and degrading treatment. The Special Rapporteur further clarified that the grounds on which a medical procedure can be performed without a person’s free and informed consent should be the same for persons with or without a disability. Yet the *Senate Inquiry Report* dismissed this, by arguing that the recommendations contained in the Special Rapporteur’s Report “do not include explicit calls for the prohibition of sterilisation without informed consent.”<sup>64</sup>
29. **In practice, this means that the status quo remains - forced sterilisation of women and girls with disabilities remains legal and sanctioned by Governments in Australia and the Australian Government remains of the view that it is an acceptable practice to sterilise children and adults with disabilities, provided that they ‘lack capacity’ and that the procedure is in their ‘best interest’, as determined by a third party.**
30. Accompanying this Submission is a copy of WWDA’s formal Submission to the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disability in Australia*. WWDA’s detailed and comprehensive Submission examines the rationale used to justify the forced sterilisation of women and girls with disabilities, including themes such as eugenics/genetics; for the good of the State, community or family; incapacity for parenthood; incapacity to develop and evolve; prevention of sexual abuse; and discourses around “best interest”. In doing so, WWDA’s Submission analyses Australian Court and Tribunal applications and authorisations for sterilisation of women and girls with disabilities, and demonstrates that in reality, applications and authorisations for sterilisation have very little to do with the ‘best interests’ of the individual concerned, and more to do with the interests of others. WWDA’s Submission demonstrates that the Australian Government’s current justification of the “best interest approach” in the sterilisation of disabled women and girls, has in effect, been used to perpetuate discriminatory attitudes against women and girls with disabilities, and has only served to facilitate the practice of forced sterilisation. WWDA’s Submission ‘*Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia*’ [ISBN: 978-0-9876035-0-0] is formally submitted as an attachment to WWDA’s Submission to the *National Inquiry into Equal Recognition Before the Law and Legal Capacity for People With Disability*.

<sup>61</sup> Frohmader, C. (2013) *Report from the United Nations Committee on the Rights of Persons with Disabilities (CRPD) 10th Session - Review of Australia*, Geneva, 2-13 September 2013. Available at: [http://www.wwda.org.au/WWDA\\_CRPD\\_Review\\_Australia\\_ReportOct13.pdf](http://www.wwda.org.au/WWDA_CRPD_Review_Australia_ReportOct13.pdf)

<sup>62</sup> Community Affairs References Committee, Op Cit.

<sup>63</sup> Méndez, Juan. E, (2013) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN General Assembly; UN.Doc A/HRC/22/53.

<sup>64</sup> Community Affairs References Committee, OpCit., at: para. 3.31, p61.

31. WWDA's Submission to the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disability in Australia* clearly demonstrates that incapacity is often used as a valid justification for Court authorisation of sterilisation of disabled women and girls, and is a major factor in all applications for authorisation of sterilisation procedures involving women and girls with disabilities. Incapacity in this context, is considered to be a fixed state, with no consideration given to the possibility of capacity evolving over time, as evident in these quotes taken from court and tribunal application transcripts:

*"Those who are severely intellectually disabled remain so for the rest of their lives".<sup>65</sup>*

*"There is no prospect that she will ever show any improvement in her already severely retarded mental state."<sup>66</sup>*

*"Katie would never be able to contribute to self-care during menstruation..... Katie is unable to understand re-production, contraception, pregnancy and birth and that inability is unlikely to change in the foreseeable future."<sup>67</sup>*

*"Sarah is unable to understand reproduction, contraception and birth and that inability is permanent.....her condition will not improve."<sup>68</sup>*

*"HGL is unlikely, in the foreseeable future, to have capacity for decisions about sterilisation."<sup>69</sup>*

*"There has been no alteration in H's capacity for eighteen months and it has been assessed that there will be no improvement in H in the future."<sup>70</sup>*

32. In the case of *Re Katie*,<sup>71</sup> for example, her lack of capacity was a key consideration in the Family Court's decision to approve her sterilisation at the age of 16. Katie was described as 'being able to finger feed, drink out of a cup and use a spoon with assistance' yet determined as not having 'the cognitive capacity to understand what is required, nor does she have the motor skills necessary to take care of her needs, i.e. to change pads'. However, it was also stated that it was 'likely that Katie will continue to make some slow progress in her development if able to participate fully in educational therapy programs. Failure to carry out the proposed surgery could significantly reduce her ability to participate in these programs.' Paradoxically, Katie was sterilised because she had 'lack of capacity to develop' but also so that she might 'develop capacity'.
33. The UN Special Rapporteur on Torture has recently re-iterated that the law should **never** distinguish between individuals on the basis of capacity or disability in order to permit sterilisation specifically of people [girls and women] with disabilities.<sup>72</sup> Yet in the 2009 case of *Re BAH*,<sup>73</sup> a 14 year old disabled girl whose mother sought to have her sterilised prior to the onset of menstruation, the NSW Guardianship Tribunal stated:

*"Ms BAH's disability is clearly central to the Tribunal's deliberations in this matter. But for Ms BAH's intellectual disability, the Tribunal would not have given consideration to the proposed treatment."*

34. The UN Special Rapporteur on Torture has also made it clear that 'best interest' and 'medical necessity' are no justification for forced/involuntary sterilisation of disabled women and girls:<sup>74</sup>

---

<sup>65</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)

<sup>66</sup> Ibid.

<sup>67</sup> Re Katie FamCA 130 (30 November 1995)

<sup>68</sup> Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993)

<sup>69</sup> HGL (No 2) [2011] QCATA 259 (19 September 2011)

<sup>70</sup> Re H [2004] FamCA 496 (20 May 2004)

<sup>71</sup> Re Katie FamCA 130 (30 November 1995)

<sup>72</sup> Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit.

<sup>73</sup> BAH [2009] NSWGT 8 (28 July 2009)

<sup>74</sup> Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit.

*"The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine."*

*"The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned. This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that.....the administration of non-consensual medication or involuntary sterilization, often claimed as being a necessary treatment for the so-called best interest of the person concerned, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of "good intentions" by medical professionals."*

35. In 2011, Mr Anand Grover, UN Special Rapporteur [on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health], in his report<sup>75</sup> on the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health [UN Doc. No: A/66/254], stated:

*"The use of.....coercion by the State or non-State actors, such as in cases of forced sterilization, forced abortion, forced contraception and forced pregnancy has long been recognized as an unjustifiable form of State-sanctioned coercion and a violation of the right to health. Similarly, where the.....law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual.....the use by States of criminal and other legal restrictions to regulate sexual and reproductive health may represent serious violations of the right to health of affected persons and are ineffective as public health interventions. These laws must be immediately reconsidered. Their elimination is not subject to progressive realization since no corresponding resource burden, or a de minimis one, is associated with their elimination."*

## **Forced Contraception**

36. Women with disabilities, like all women, have a right to safe and effective contraception. Yet widespread discriminatory attitudes which portray women with disabilities as either asexual or hyper-sexual, often see them denied this most basic right. These pervasive negative attitudes, values and stereotypes about the reproductive capacity of women with disabilities make getting accurate information about contraceptive options very difficult. Although the contraceptive needs of women with disabilities are essentially no different from those of the general population,<sup>76</sup> the pattern of contraceptive use amongst women with disabilities and non-disabled women, differs widely. Women with disabilities (particularly those with intellectual disabilities) are more likely to be sterilised, more likely to be prescribed long-acting, injectable contraceptives and less likely to be prescribed oral contraceptives. In addition, women with disabilities are much less likely to be involved in choice and decision-making around the type of contraception they use.<sup>77</sup> In the case

<sup>75</sup> UN General Assembly, Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Mr Anand Grover; 3 August 2011; UN Doc. No: A/66/254.

<sup>76</sup> Frohmader, C. (2013) OpCit., Dowse, L. (2004) 'Moving Forward or Losing Ground? The Sterilisation of Women and Girls with Disabilities in Australia'. Available online at: <http://www.wvda.org.au/steril3.htm>; Jones M. & Basser Marks L. (1997) Female and Disabled: A Human Rights Perspective on Law and Medicine in K. Petersen (ed) *Intersections: Women on Law, Medicine and Technology* Aldershot, Dartmouth: 49-71.

<sup>77</sup> O'Connor, J. *Literature Review on Provision of Appropriate and Accessible Support to People with an Intellectual Disability who are Experiencing Crisis Pregnancy*. Available at: <http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/200FC923F86AE299802577A4003355CF?OpenDocument>

of women with intellectual disabilities, the decision about type of contraception is almost exclusively made by someone else, such as a doctor and/or guardian, parent, or carer.<sup>78</sup>

37. Forced contraception, recognised as a form of torture,<sup>79</sup> is commonly used on women and girls with disabilities in Australia to suppress menstruation or sexual expression for various purposes, including eugenics-based practices of population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse).<sup>80</sup> For example, the disproportionate use of Depo-Provera and other long acting contraceptives on women with disabilities (including those who are not sexually active, or who are yet to begin menstruation), has been recognised for some time in a number of different countries, including Australia.<sup>81</sup> It is very much a contemporary and widespread problem, and illustrates that the legacy of past eugenic ideologies and practices has far from disappeared.
38. Forced contraception practices are often undertaken under the guise of 'behaviour management' strategies or treatment for 'unwanted' or 'offending sexual behaviour'. These practices are rarely, if ever, subject to independent monitoring or review. For example, the use of Depo Provera and other long acting contraceptive medications, used to suppress menstruation in women and girls with disabilities living in institutions or other residential settings, often occurs through an 'arrangement' between the institution or residential setting and a doctor.<sup>82</sup> These types of contraceptives are used to suppress menstruation in women and girls with disabilities as a first and only response to what is deemed by others as 'inappropriate behaviour', such as removing sanitary pads in public or not disposing of them appropriately in a waste-bin. Sex education, menstrual management strategies and supports for the individuals and families concerned are rarely available or even considered.
39. Men and boys with disabilities (particularly those with intellectual disabilities or psychosocial disabilities) also experience violations of their sexual and reproductive rights in a number of ways. They are forced or coerced into undergoing vasectomies before they can enter into marriage or continue sexual relationships; or after they have had a child. Research conducted in the late 1990s in Australia found that it was likely that orchidectomies, or castration by surgical removal of the testes were being performed on boys and young men with disabilities in the absence of disease or health risks. Depo Provera and anti-androgenic medications are being prescribed to boys and men with disabilities to prevent sexual behaviour that is viewed as unwanted or excessive. Although the behaviour may be typical of the sexual behaviour of boys and young men without disabilities, the response is to 'treat' the behaviour as if it is inappropriate. Depo Provera and anti-androgenic medications are being prescribed to boys and men with disabilities to prevent inappropriate sexual behaviour, such as masturbation in public. In many situations, these boys and men may not have received sex education or positive behaviour supports. Rather than consider supports, sex education and counselling for the individuals and families concerned, the first and only response is suppression of sexual functioning.<sup>83</sup>

---

<sup>78</sup> Frohmader, C. and Ortoleva, S. (July 2013) *The Sexual and Reproductive Rights of Women and Girls with Disabilities*; Issues Paper commissioned by the ICPD International Conference on Human Rights, The Hague, July 2013. Available at: [http://www.wwda.org.au/issues\\_paper\\_srr\\_women\\_and\\_girls\\_with\\_disabilities\\_final.pdf](http://www.wwda.org.au/issues_paper_srr_women_and_girls_with_disabilities_final.pdf)

<sup>79</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.

<sup>80</sup> Frohmader, C. (2013) OpCit.

<sup>81</sup> McCarthy, M. (2009) 'I have the jab so I can't be blamed for getting pregnant': Contraception and women with learning disabilities. *Women's Studies International Forum*, 32, pp. 198-208

<sup>82</sup> People With Disability Australia (PWDA) (March 2013) *Submission to the Senate Standing Committee on Community Affairs: Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia*. PWDA, Sydney, Australia.

<sup>83</sup> Ibid.

## Systemic Denial of Access to Sexual & Reproductive Health Services, Programs, Information & Education

40. The right to participate in all decision-making processes that affect sexual and reproductive health and development is a basic right of all women, including women and girls with disabilities. Yet, more often than not, many women and girls with disabilities are excluded from participating in decisions that affect their lives on a daily basis, including as active partners in their own sexual and reproductive health care. They are further excluded and ignored in sexual and reproductive health policy, service and program development, including information and education resources.<sup>84</sup>
41. The discrimination experienced by women with disabilities is played out in their access to and use of sexual and reproductive health services and programs. For many, the services and programs they require to realise their sexual and reproductive rights are simply not *available* to them. Even where services and programs are available, many women with disabilities remain excluded due to economic, social, psychological and cultural barriers that impede or preclude their access. For example, support for choices and services in menstrual management, contraception, abortion, sexual health management, pregnancy, birth, parenting, assisted reproduction, and menopause remain inappropriate, absent or inaccessible. Breast and cervical cancer screening services are often not available or accessible to women with disabilities, yet a disproportionate number of deaths from breast and cervical cancer occur among women with disabilities.<sup>85</sup> Services and programs for women with disabilities experiencing, or at risk of violence is a further area where women with disabilities experience exclusion and often when a woman with a disability is seen by health care workers, they fail to perform screenings for possible domestic and other forms of violence based on stereotypical attitudes. Even where sexual and reproductive health services and programs are available, women with disabilities are inadequately served, due to a wide range of factors, such as: inaccessible venues; lack of transport; lack of appropriate equipment; non-inclusive and/or inflexible service policies and programs; lack of skilled workers; and pervasive stereotypes and assumptions that women with disabilities are asexual.<sup>86</sup>
42. Health practitioners and workers have long been seen as complicit in denying women with disabilities their sexual and reproductive rights, and in perpetuating myths and negative stereotypes about women with disabilities.<sup>87</sup> The lack of education and training of health providers has been identified as a major barrier to women with disabilities accessing sexual and reproductive health services. This lack of education and training is borne out in a myriad of ways. For example, many practitioners lack knowledge of disability, hold inaccurate perceptions about women with disabilities, and have a tendency to view women with disabilities solely through the lens of their impairments. Insufficient time to address the full range of needs is a common barrier during encounters with practitioners, as is the general lack of sensitivity, responsiveness, courtesy and support shown to women with disabilities. Health practitioners can have a tendency to treat women with disabilities as objects of treatment rather than rights-holders, and do not always seek their free and informed consent when it comes to interventions.<sup>88</sup>
43. For many women and girls with disabilities, knowledge of sexual and reproductive rights and health has been shown to be poor and access to information and education limited. Women with disabilities express desires for intimate relationships but report limited opportunities and difficulty negotiating relationships.<sup>89</sup> For women with intellectual disabilities in particular, attitudes toward sexual expression remain restrictive and laws addressing sexual exploitation may be interpreted by others as prohibition of relationships.<sup>90</sup> Paternalistic and stereotypical

---

<sup>84</sup> WWDA (2010) *Women With Disabilities & The Human Right to Health: A Policy Paper*. Available online at: <http://www.wwda.org.au/health2006.htm>

<sup>85</sup> Thierry, J. (2000) Increasing breast and cervical cancer screening among women with disabilities. *Journal of Women's Health & Gender-Based Medicine*, Vol. 9, No.1, pp.9-12.

<sup>86</sup> Frohmader, C. and Ortoleva, S. (July 2013) OpCit.

<sup>87</sup> Mall, S., & Swartz, L. (2012) Editorial: Sexuality, disability and human rights: Strengthening healthcare for disabled people. *South African Medical Journal*, Vol. 102, No. 10, October 2012.

<sup>88</sup> Ibid.

<sup>89</sup> In Frohmader, C. (2013) OpCit.

<sup>90</sup> Eastgate, G., Scheermeyer, E., van Driel, M. & Lennox, N. (2012) Intellectual disability, sexuality and sexual abuse prevention: A study of family members and support workers. *Australian Family Physician* Vol. 41, No. 3, pp. 135-139.

attitudes towards women and girls with disabilities, often result in others deciding on a disabled woman or girls behalf what is in their 'best interests'. It is clear that negative attitudes, values and stereotypes about the reproductive capacity of women with disabilities influences decisions taken about their sexual and reproductive rights. When these negative attitudes are combined with authority and power, they are a potent combination.<sup>91</sup>

## Case Examples

*Adult male and female residents of a group home run by a religious organisation, are prohibited from having any form of sexual or intimate relationships on the premises (either with each other or anyone else), as this is deemed to breach organisational policy and house rules. Although the residents are part of the local community and participate in activities outside the group home, they are prohibited from bringing a sexual or intimate partner to the home. Instead, the residents are told that if they want to have sex it has to occur off site. Several of the residents confirm that they have had sex in the local park, and the supermarket car park.*

*A male disability support worker from a government funded group home, boasted that the female residents in the group home where he worked, were all "given the Primolut" without the placebo tablets so that they didn't get their periods. When asked why this was the practice, the disability support worker replied that "It's not our job to deal with periods" and that it "makes it easier for us to look after them."*

*A mother of a 24 year old woman with a mild intellectual disability seeks information as to whether she can get a restraining order against a man with an intellectual disability who has struck up a friendship with her daughter. She confirms that her daughter is happy in the man's company and wants to spend more time with him. When asked why she wants to take out a restraining order against the young man, the mother advises that she doesn't want her daughter to mix with him in case they want to have sex.*

---

<sup>91</sup> McCarthy, M. (2009) OpCit.



## The Right to Freedom from Violence, Abuse, Exploitation and Neglect

---

44. International human rights law condemns violence against women in all its forms, whether it occurs in the home, schools, in institutions, the workplace, the community or in other public and private institutions, and regardless of who perpetrates it. Human rights standards guarantee the right to be free from violence, torture, and cruel, inhuman, or degrading treatment or punishment, as well as the rights to life, health, liberty, security of person, and non-discrimination. These guarantees create a government duty to respect, protect, fulfil and promote human rights with regard to violence against women including the responsibility to prevent, investigate and prosecute all forms of, and protect all women from such violence and to hold perpetrators accountable.<sup>92</sup>
45. The Australian Government has consistently articulated its commitment to meeting its obligations under the treaties it has ratified,<sup>93</sup> and has made it clear that it views freedom from violence as a pre-requisite to women's exercise and enjoyment of human rights.<sup>94</sup> It has also conceded that violence against women with disabilities in Australia is 'widespread', that women with disabilities, particularly intellectual disabilities, are extraordinarily vulnerable to violence and abuse, and that disabled women experience significant barriers in accessing domestic/family violence and sexual assault services and support.<sup>95</sup> Yet successive Australian Governments have shown little interest in, and taken minimal action to address violence against women and girls with disabilities. There have been, and remain, significant systemic failures in legislation, regulatory frameworks, policy, administrative procedures, availability and accessibility of services and support, to prevent and address violence against women and girls with disabilities.
46. Violence against women and girls with disabilities, in all its forms, is widespread and unaddressed in Australia. Women and girls with disabilities experience, and are extraordinarily vulnerable to multiple forms of violence, exploitation and abuse. Although women and girls with disabilities experience many of the same forms of violence that all women experience, when gender and disability intersect, violence has unique causes, takes on unique forms and results in unique consequences. Women and girls with disabilities also experience forms of violence that are particular to their situation of social disadvantage, cultural devaluation and increased dependency on others. Poverty, race, ethnicity, religion, language and other identity status or life experiences can further increase their risk of violence.<sup>96</sup>
47. Compared to non-disabled women, women with disabilities experience violence at significantly higher rates, more frequently, for longer, in more ways, and by more perpetrators, yet legislative responses, programs and services for this group either do not exist, are extremely limited, or simply just exclude them. Research shows that:
- women with disabilities experience violence, particularly family/domestic violence, violence in institutions, and violence in the workplace, more often than disabled men,<sup>97</sup> are often at greater risk than disabled men, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation;<sup>98</sup> and, are more vulnerable as victims of crimes from both strangers and people who are known to them;<sup>99</sup>
  - women with disabilities are more exposed to forms of violence which qualify as torture or inhuman or degrading treatment<sup>100</sup> (such as forced or coerced sterilisation, forced abortion,

---

<sup>92</sup> United Nations General Assembly (2006) *In-depth study on all forms of violence against women*. Report of the Secretary-General. A/61/122/Add.1. New York.

<sup>93</sup> Commonwealth of Australia (2010) *Australia's Human Rights Framework*, Attorney-General's Department, Canberra.

<sup>94</sup> Commonwealth of Australia (2012) *Information provided in follow-up to the concluding observations of the CEDAW Committee [Australia]*; Responses by Australia to the recommendations contained in the concluding observations of the Committee following the examination of the combined sixth and seventh reporting periodic report of Australia on 20 July 2010.

<sup>95</sup> In Frohmader, C. (2011) Op Cit.

<sup>96</sup> Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia*. Background Paper. Hobart: Women with Disabilities Australia.

<sup>97</sup> Women With Disabilities Australia (WWDA) (2007b) OpCit.; Meekosha, H. (2004) OpCit.

<sup>98</sup> See Preamble [q] of UN General Assembly, *Convention on the Rights of Persons with Disabilities*.

<sup>99</sup> Groce, N. (2006) OpCit.

<sup>100</sup> Committee of Ministers of the Council of Europe (2009) OpCit.

- forced contraception, gender based violence, chemical restraint, forced electro-shock, and other forced psychiatric interventions);
- sexual assault and abuse is a significant and un-addressed problem for girls and women with disabilities, particularly for those in 'institutional' settings;<sup>101</sup>
  - more than 70% of women with a wide variety of disabilities have been victims of violent sexual encounters at some time in their lives;<sup>102</sup>
  - the rates of sexual victimisation of girls and women with disabilities ranges from four to 10 times higher than for non-disabled women and girls;<sup>103</sup>
  - the overwhelming majority of perpetrators of sexual abuse of disabled girls and women in institutions are male caregivers, a significant portion of whom are paid service providers who commit their crimes in disability service settings, and other forms of institutional settings;<sup>104</sup>
  - perpetrators frequently target and select women and girls with disabilities for their perceived powerlessness and vulnerability - and for their seeming limitations;<sup>105</sup>
  - crimes of sexual violence committed against girls and women with disabilities often go unreported, and when they are, they are inadequately investigated, remain unsolved or result in minimal sentences;<sup>106</sup>
  - lack of reporting of sexual abuse of girls and women with disabilities in institutions, and cover up by staff and management, is acknowledged as a widespread and common problem in Australia,<sup>107</sup> and remains a significant factor in the lack of police investigation, prosecution and conviction of perpetrators;
  - police are often reluctant to investigate or prosecute when a case involves a girl or woman with a disability in an institutional setting; and they also fail to act on allegations because there is no 'alternative to the abusive situation';<sup>108</sup>
  - girls and women with disabilities, particularly those with intellectual and/or cognitive disabilities and/or psychosocial disabilities have less chance of being believed when reporting sexual assault, violence and abuse than non-disabled women and girls.<sup>109</sup>

48. These recent examples highlight some of these facts:

*In June 2011, the South Australian Health Complaints Commissioner reported that there had been five cases of rape and serious sexual assault against girls and women with disabilities in the past year and, in the worst case of abuse in care, a 15 year old victim had become pregnant with the suspected rapist's child but the man had disappeared before any action could be taken against him. None of the five cases resulted in any serious police action because of a lack of corroboration or the extent of the impairment of the alleged victim.*<sup>110</sup>

*In July 2011, authorities in South Australia decided not to proceed with a case claiming sexual abuse of a child with an intellectual disability. The prosecution formed the view that the child could not give reliable evidence. The accused was released. Although it transpired that up to 30 other intellectually disabled children had been abused by the accused (a volunteer bus driver with a school for intellectually disabled children) and introduced into a ring of paedophiles,<sup>111</sup> the police and the school authorities did not tell all the parents whose children had*

<sup>101</sup> In Frohmader, C. (2011) Submission to the UN Analytical Study on Violence against Women and Girls with Disabilities. WWDA, Tasmania.

<sup>102</sup> Stimpson & Best; cited in Elman, A. (2005). *Confronting the Sexual Abuse of Women with Disabilities*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence.

<sup>103</sup> Baladerian; Valenti-Hein & Schwartz; cited in Elman, A. (2005) OpCit.

<sup>104</sup> Sobsey & Doe; cited in Elman, A. (2005) OpCit.

<sup>105</sup> Elman, A. (2005) OpCit. See also WWDA (2007b) OpCit.

<sup>106</sup> WWDA (2007b) OpCit. See also: Healey et al (2008) OpCit; See also: French, P., Dardel, J., & Price-Kelly, S. (2009) *Rights denied: Towards a national policy agenda about abuse, neglect and exploitation of persons with cognitive impairment*, People with Disability Australia, Sydney.

<sup>107</sup> French, P. (2007) French, P. (2007) *Disabled Justice: The barriers to justice for persons with disability in Queensland*. Queensland Advocacy Incorporated (QAI), Brisbane. Accessed online October 2011 at: [http://www.qai.org.au/images/stories/docs/1987-2007/doc\\_199.pdf](http://www.qai.org.au/images/stories/docs/1987-2007/doc_199.pdf); See also: Stewart, D. Chapter 11 Institutional culture and people with intellectual disabilities: Experiences of an inquirer. In Hauritz, M. Sampford, C. & Blencowe, S. (Eds) (1998) *Justice for People with Disabilities – Legal and Institutional Issues*. The Federation Press, Leichhardt, NSW; See also: French, P. et al (2010) OpCit.

<sup>108</sup> French, P. (2007) OpCit; See also: French, P. et al (2010) OpCit.

<sup>109</sup> In Frohmader, C. (2011) OpCit.

<sup>110</sup> Ibid.

<sup>111</sup> Australian Broadcasting Corporation (ABC) (2011) *Church denies disabled kids' sex abuse cover-up*. ABC TV 'Four Corners' September 26, 2011. Accessed online October 2011 at: <http://www.abc.net.au/news/2011-09-26/four-corners-child-abuse-claims/2942602>



come into contact with the accused.<sup>112</sup> It was only as a result of a chance encounter between the parents, that the full extent of their children's abuse was revealed.

*In November 2011, it was reported that a major mental health service in Victoria has been covering up sexual assaults of its patients, and that the same service has been previously investigated for allegedly failing to protect an intellectually disabled teenage girl from being sexually exploited by a 34 year old male patient. The latest allegations involved a 20 year old female mental health patient allegedly sexually assaulted by a male nurse. When the young woman complained to a female staff member, she was told not to tell anyone else about it to avoid it "becoming office gossip". Police investigated the case but did not lay charges on the grounds it would be difficult to prosecute. An internal investigation was conducted and "appropriate disciplinary action implemented" however, it is not known what disciplinary action was taken, and it has been reported that 'soon after the alleged incidents' the male nurse resumed working in mental health services, and 'remains in a role where he interacts with female patients'.<sup>113</sup>*

*In 2010, three intellectually disabled women living in accommodation run by the Victorian Department of Human Services were allegedly raped and assaulted after being left alone with a male carer in the state-run house.<sup>114</sup> The mother of one of the women said that her daughter was "covered in bruises" after the alleged attack but did not receive counselling until 10 days later, and even then the women were only given one session of one-on-one counselling.<sup>115</sup> It was only after the media reported the story that the Department of Human Services undertook 'an internal investigation' and police became involved. However, the outcome of the 'internal investigation' is unknown, as is the result of the police investigation. This lack of transparency is a familiar theme in cases of violence and abuse against women and girls with disabilities.*

49. Many forms of violence perpetrated against women and girls with disabilities (such as violence in institutions; sexual and reproductive rights violations; restrictive practices; seclusion and restraint; deprivation of liberty; forced psychiatric interventions), remain unexplored and unaddressed in the Australian context, and fall outside the scope of Australian family/domestic violence legislation and policy responses to addressing violence against women.
50. Women and girls with disabilities in Australia continue to be subjected to multiple forms and varying degrees of 'deprivation of liberty' and are subjected to unregulated or under-regulated restrictive interventions.<sup>116</sup> This is particularly the case for women and girls with intellectual and/or cognitive disabilities, developmental disabilities and those with psychosocial disabilities. A restrictive intervention has been defined as '*any intervention that is used to restrict the rights or freedom of movement of a person with a disability*',<sup>117</sup> and can include practices such as chemical restraint,<sup>118</sup> mechanical restraint,<sup>119</sup> physical restraint,<sup>120</sup> social restraint,<sup>121</sup> seclusion<sup>122</sup>. Such

<sup>112</sup> Australian Broadcasting Corporation (ABC) (2011) *St Ann's Secret*. ABC TV 'Four Corners', October 3, 2011. Accessed online October 2011 at: <http://www.abc.net.au/4corners/stories/2011/09/22/3323669.htm>

<sup>113</sup> Baker, R. & McKenzie, N. (2011) Patient 'silenced' after sex abuse. *The Age*, November 21, 2011. Accessed online November 2011 at: <http://www.theage.com.au/victoria/patient-silenced-after-sex-abuse-20111120-1npeh.html>

<sup>114</sup> Mickelborough, P. (2010) Mentally disabled women 'raped by carer' in state-run house. *Herald Sun*, October 11, 2010. Accessed online October 2011 at: <http://www.heraldsun.com.au/news/victoria/mentally-disabled-women-raped-by-carer-in-state-run-house/story-e6frf7kx-1225936849896>

<sup>115</sup> Grace, R. (2010) Rape claims levelled against DHS worker. *The Age*, October 11, 2010. Accessed online October 2011 at: <http://www.theage.com.au/victoria/rape-claims-levelled-against-dhs-worker-20101011-16erd.html>

<sup>116</sup> Office of the Public Advocate (2010) *Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper*. Accessed online October 2011 at: <http://www.publicadvocate.vic.gov.au/file/Research/Submissions/2010/OPA-Submission-to-VLRC-May-2010.pdf> See also: French, P., Dardel, J. & Price-Kelly, S. (2010) OpCit.

<sup>117</sup> Office of the Public Advocate (2010) *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected?* Accessed online October 2011 at: <http://www.publicadvocate.vic.gov.au/file/Research/Reports/STOs%20in%20Practice,%20How%20are%20the%20HRs%20of%20People%20Detained%20under%20the%20Disability%20Act%202006%20Protected.pdf>

<sup>118</sup> Chemical restraint occurs when medication that is sedative in effect is prescribed and dispensed to control the person's behaviour rather than provide treatment. See in: National Mental Health Consumer & Carer Forum (2009) *Ending Seclusion and Restraint in Australian Mental Health Services*. [www.nmhccf.org.au](http://www.nmhccf.org.au)

<sup>119</sup> Mechanical restraint is understood as the use of any device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioural control. See for eg: McVilly, K. (2008). *Physical restraint in disability services: current practices; contemporary concerns and future directions*. A report commissioned by the Office of the Senior Practitioner, Department of Human Services, Victoria, Australia.

practices are often imposed as a means of coercion, discipline, convenience, or retaliation by staff, family members or others providing support.<sup>123</sup> These practices are not limited to institutions such as group homes, but also occur in educational settings (such as schools), hospitals, residential aged care facilities and other types of institutions (such as hostels, boarding houses, psychiatric/mental health community care facilities, prisons, supported residential facilities).

51. The Victorian Government has estimated that between 44-80% of people with disabilities who 'show behaviours of concern' are prescribed chemical restraint.<sup>124</sup> No controlled studies exist that evaluate the value of seclusion or restraint in those with 'serious mental illness',<sup>125</sup> although the use of involuntary seclusion and restraint in all forms is an everyday occurrence, particularly in Australia's public acute inpatient facilities.<sup>126</sup> The widespread, systemic problem of restrictive practices and children with disabilities in Australian schools remains ignored and unaddressed by Governments.<sup>127</sup>
52. All Australian states and territories have provisions for the 'treatment' of people with mental illnesses without consent.<sup>128</sup> This occurs when the persons illness is believed to impair his or her capacity to understand the need for treatment, or where the person is likely to put themselves or others at risk in some substantial way.<sup>129</sup> Legislation typically allows for involuntary admission to hospital and, in most jurisdictions, pharmacological or other treatments without consent.
53. In most States and Territories of Australia, involuntary electroconvulsive therapy (ECT) requires the approval of the relevant Mental Health Review Tribunal, except in Tasmania (where approvals are made by the Guardianship and Administration Board) and in Victoria, where current legislation allows treating psychiatrists to administer ECT without consent or external review.<sup>130</sup> Data on the use of Electroconvulsive therapy (ECT) on involuntary persons in Australia is difficult to source, however, where it is available, indicates that three times more women than men are subject to the practice.<sup>131</sup> Medicare statistics for 2007-2008 record 203 ECT treatments on children younger than 14 - including 55 aged four and younger.<sup>132</sup> Certain legislation in Australia currently allows for children to undergo ECT provided they, or their parent or guardian have given informed consent.<sup>133</sup>
54. In 2009-10 the Queensland Mental Health Tribunal scheduled 462 ECT applications in relation to 355 patients. This was 15.5% higher than the previous year. Of these, 98 (21.2%) were

<sup>120</sup> Physical restraint is defined as the sustained or prolonged use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of another person. See for eg: McVilly, K. (2008) OpCit.

<sup>121</sup> Social restraint is recognized to include the use of verbal interactions and/or threats of social or other tangible sanctions, which rely on eliciting fear to moderate a person's behavior. See for eg: McVilly, K. (2008) OpCit.

<sup>122</sup> In Australia the definition of seclusion is both legislated and policy driven. Seclusion can be understood as 'the confinement of a person alone at any hour of the day or night in a room, the door(s) and window(s) of which cannot be opened by the person from the inside; or the confinement of a person alone at any hour of the day or night in a room in which the door(s) or window(s) are locked from the outside or their opening is prevented by any other means, such as a person holding the door shut; or where exit from a place is prevented by the presence of another person.

<sup>123</sup> Cited in McVilly, K. (2008). OpCit.

<sup>124</sup> Department of Human Services (2008) Positive Solutions in Practice: *Chemical Restraint: What every Disability Support Worker needs to know*. Office of the Senior Practitioner, Melbourne.

<sup>125</sup> Sailas EES, Fenton M. (2000) *Seclusion and restraint for people with serious mental illnesses*. Cochrane Database of Systematic Reviews 2000, Issue 1. Art. No.: CD001163. DOI: 10.1002/14651858.CD001163.

<sup>126</sup> National Mental Health Consumer & Carer Forum (2009) OpCit.

<sup>127</sup> See for eg: Australian Broadcasting Corporation (ABC TV) (17/05/2011) 'Hidden shame'; 7.30 Report. Accessed online October 2011 at: <http://www.abc.net.au/7.30/content/2011/s3219518.htm> See also: Martin, L. (March 11, 2010) 'Outrage over Seven Hills West Public School putting autistic children in cage'; Accessed online October 2011 at: <http://www.news.com.au/national/outrage-over-seven-hills-west-public-school-putting-autistic-kids-in-cage/story-e6frfkvr-1225839691640> See also: Brown, D. (2010) 'Autistic kids 'caged' at school.' *The Mercury Newspaper*, September 13, 2010. Accessed: [http://www.themercury.com.au/article/2010/09/13/172495\\_tasmania-news.html](http://www.themercury.com.au/article/2010/09/13/172495_tasmania-news.html)

<sup>128</sup> For a detailed analysis of forced psychiatric interventions and practices, see the *Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)* at: <http://www.chrusp.org>

<sup>129</sup> Fitzgerald, P. (2011) 'It's time to move on from ECT's shocking past.' *The Conversation*; 29 September 2011; Accessed online October 2011 at: <http://theconversation.edu.au/its-time-to-move-on-from-ects-shocking-past-3312>

<sup>130</sup> Baker, R. & McKenzie, N. (2011) Mental health care inquiry. *The Age*, Accessed online October 2011 at: <http://www.theage.com.au/victoria/mental-health-care-inquiry-20110905-1juiy.html>

<sup>131</sup> In Frohmader, C. (2011) OpCit.; See Also: 'Child shock therapy'; *Herald Sun Newspaper*, January 25, 2009. Accessed online December 2012 at: <http://www.heraldsun.com.au/news/victoria/child-shock-therapy/story-e6fr7kx-1111118657718>

<sup>132</sup> 'Child shock therapy'; *Herald Sun Newspaper*, January 25, 2009. Accessed online December 2012 at: <http://www.heraldsun.com.au/news/victoria/child-shock-therapy/story-e6fr7kx-1111118657718>

<sup>133</sup> See for example: *Western Australia [Draft] Mental Health Bill 2012*. Accessed online December 2011 at: [http://www.mentalhealth.wa.gov.au/Libraries/pdf\\_docs/Green\\_paper-Mental\\_Health\\_Bill\\_2012\\_325-1.sflb.ashx](http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Green_paper-Mental_Health_Bill_2012_325-1.sflb.ashx)

applications for patients undergoing emergency ECT.<sup>134</sup> In 2009-10 in NSW, 716 applications were made to the NSW Mental Health Review Tribunal to administer ECT to involuntary patients (455 or 63.5% of the applications involved female patients). Only 20% of the 716 applications included legal representation for the patient. The NSW Mental Health Act 2007 allows for determinations of more than 12 ECT treatments 'if the Tribunal is satisfied that more are justified, having regard to the special circumstances of the case.' In 2009-10, 5.4% of cases were for more than 12 treatments approved.<sup>135</sup>

55. In Victoria in 2009-10, more than 1100 people received electroconvulsive therapy (ECT), in the public mental health system. Of these, 377 (or about one third) were deemed involuntary patients who did not consent to the ECT. Involuntary mental health patients received more than half of the 12,968 ECT sessions administered in the Victorian public psychiatric system in 2009-10.<sup>136</sup> The use of ECT in Victoria's public and private psychiatric services has increased sharply in recent years. In public mental health services, its use has increased by 12% since 2003-04, and private ECT sessions in Victoria have increased by 71% during the same period.<sup>137</sup> An 2011 investigation into Victoria's mental health system reported that:

*'Practices from a previous age appear routine in some hospitals: threatening patients with electroconvulsive therapy (ECT) if they refuse to take medication; locking bathrooms to prevent patients drinking water, which would negate the effect of the ECT; and imposing a form of solitary confinement as punishment for improper behaviour. Such attempts to subdue and control patients are disturbing enough in fiction such as One Flew Over the Cuckoo's Nest; they have no place in hospitals in 21st century Australia.'*<sup>138</sup>

56. In October 2013, the Committee on the Rights of Persons with Disabilities in *Concluding Observations [Australia]* expressed its concern that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion, in environments including schools, mental health facilities and hospitals. The Committee recommended that Australia:

*take immediate steps to end such practices including by establishing an independent national preventative mechanism to monitor places of detention including mental health facilities, special schools, hospitals, disability justice centres and prisons, to ensure that persons with disabilities including those with psychosocial disabilities are not subjected to intrusive medical interventions.*

57. The Committee also expressed its concern that under Australian law, a person can be subjected to medical interventions against his or her will, if the person is deemed to be incapable of making or communicating a decision about treatment. The Committee recommended that:

*Australia repeal all legislation that authorises medical interventions without free and informed consent of the persons with disabilities concerned, and legal provisions that authorize commitment of individuals to detention in mental health services, or the imposition of compulsory treatment either in institutions or in the community via Community Treatment Orders (CTOs).*

58. The UN Special Rapporteur on Torture, in his ground-breaking report of 2013<sup>139</sup> which clarified practices that constitute torture and ill-treatment in health-care settings, made it clear that women living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of

<sup>134</sup> Queensland Government (2010) *Mental Health Review Tribunal Annual Report 2009-10*. Accessed October 2011 at:

<http://www.mhrt.qld.gov.au/wp-content/uploads/2010/12/mhrt-annual-Report-2009-10.pdf>

<sup>135</sup> NSW Mental Health Review Tribunal (2010) *Annual Report of the Mental Health Review Tribunal*. Accessed online October 2011 at:

<http://www.mhrt.nsw.gov.au/mhrt/pdf/Annualreport200910.pdf>

<sup>136</sup> Baker, R. & McKenzie, N. (2011) OpCit.

<sup>137</sup> Ibid.

<sup>138</sup> The Age Newspaper; *Silence hides shameful neglect of mentally ill*; September 5, 2011; Accessed online October 2011 at:

<http://www.theage.com.au/opinion/editorial/silence-hides-shameful-neglect-of-mentally-ill-20110904-1js7t.html>

<sup>139</sup> Méndez, Juan, E. (2013) UN.Doc A/HRC/22/53, Op Cit.

discrimination and abuse in health-care settings. He also confirmed that any restraint on people with 'mental disabilities' [sic] for even a short period of time may constitute torture and ill-treatment. His report states:

*It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.*

59. The UN Special Rapporteur on Torture has also made it clear that, as detention in a psychiatric context may lead to non-consensual psychiatric treatment, deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture (CAT).<sup>140</sup>

60. The UN Special Rapporteur on Torture has strongly recommended<sup>141</sup> that States Parties (which includes Australia):

*Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity.*

*Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation.*

*Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.*

61. The Australian Government's primary response to addressing violence against women in Australia, including women with disabilities, is through the twelve year *National Plan to Reduce Violence against Women and their Children 2010-2022*, [the National Plan] and its National and jurisdictional Implementation Plans. However, in relation to addressing violence against women and girls with disabilities, the National Plan has significant limitations, in that there is little emphasis on girls with disabilities, it focuses only on domestic/family violence and sexual assault and fails to address the multiple forms of violence that women and girls with disabilities experience. In addition, although Aboriginal and Torres Strait Islander women are included in the National Plan and other mainstream strategies, there are no clear provisions which address violence and abuse of Aboriginal and Torres Strait Islander women with disabilities, and this remains an unaddressed area of public policy and service provision. A similar situation exists for culturally and linguistically diverse (CALD) women with disabilities. Whilst it could be argued that the *National Disability Strategy* (NDS) might address these forms of violence, most state and

---

<sup>140</sup> Ibid.

<sup>141</sup> Ibid.

territory NDS Implementation Plans (where the NDS is operationalised), rely on, and cite the *National Plan* as the key (and often only) strategy to address violence against people with disabilities. Regrettably, the majority of these NDS Implementation Plans are un-gendered. This type of policy 'silencing', and lack of understanding of the gendered nature of violence against people with disabilities, can contribute to women with disabilities who experience, and who are at risk of experiencing violence, falling through violence prevention legislation, policy, program and service delivery gaps.

62. For example, women and girls with disabilities in Australia live in and experience, a vast range of 'institutional' settings, such as group homes, supported residential facilities, licenced and un-licenced boarding houses, psychiatric/mental health community care facilities, residential aged care facilities, hostels, hospitals, prisons, foster care, respite facilities, cluster housing, congregate care, special schools and out-of-home care services. Women and girls with disabilities in institutions are at particular and significant risk of violence, abuse and exploitation due to a range of factors, including: the reinforced demand for compliant behaviours, their perceived lack of credibility, their social isolation and lack of access to learning environments, their dependence upon others, their lack of access to police, support services, lawyers or advocates; the lack of public scrutiny of institutions; and the entrenched sub-culture of violence and abuse prevalent in institutions.<sup>142</sup> Violence perpetrated against women and girls with disabilities in institutions is rarely characterised as domestic/family violence and rarely are domestic/family violence related interventions deployed to deal with this type of violence.
63. Violence against women and girls in institutions in Australia has consistently been identified as an urgent issue requiring national leadership, and a national public policy response. This was recently reinforced by participants and delegates at the '*National Symposium on Violence Against Women and Girls with Disabilities*'<sup>143</sup> where there was unanimous and unequivocal consensus calling for urgent action on this issue. For a number of years now, women with disabilities, disabled people's organisations, human rights organisations, and the United Nations (amongst others), have called for urgent action by Australian governments to address violence, exploitation, and abuse experienced by women and girls with disabilities in institutions. Yet in Australia, this issue remains excluded from public programmes and policies on the prevention of gender-based violence. Recent media reports<sup>144</sup> on the systemic nature of violence against people with disabilities in institutions throughout Australia further demonstrate and reinforce the need for urgent national action on this issue.
64. Most recently, in October 2013, the *Committee on the Rights of Persons with Disabilities* in its Concluding Observations following its Review of Australia's compliance with the CRPD, expressed its "deep concern" at the high rates of violence perpetrated against women and girls with disabilities<sup>145</sup> and recommended that Australian Governments act urgently to:
  - address and investigate, without delay, violence, exploitation and abuse experienced by women and girls with disabilities in institutional settings;
  - include a more comprehensive consideration of women with disabilities in public programmes and policies on the prevention of gender-based violence;
  - ensure access for women with disabilities to an effective, integrated response system; and,
  - commission and fund a comprehensive assessment of the situation of girls and women with disabilities in Australia.

<sup>142</sup> SafePlace Institute (2000) *Stop the Violence, Break the Silence Training Guide & Resource Kit*. Austin, Texas.

<sup>143</sup> The '*National Symposium on Violence Against Women and Girls with Disabilities*' was held in Sydney on October 25<sup>th</sup> 2013, as a component of WWDA's National COAG Reform Project on Violence Against Women and Girls with Disabilities. See: [www.stvp.org.au](http://www.stvp.org.au)

<sup>144</sup> The Age Newspaper (November 20, 2013) '*Former Yooralla worker Vinod Kumar jailed for attacking vulnerable women in his care*'; at: <http://www.theage.com.au/victoria/former-yooralla-worker-vinod-kumar-jailed-for-attacking-vulnerable-women-in-his-care-20131120-2xuh3.html> See also: The Age Newspaper (November 21, 2013) '*Yooralla senior executives accused of ignoring warning signs on rape claims*'; at: <http://www.theage.com.au/victoria/yooralla-senior-executives-accused-of-ignoring-warning-signs-on-rape-claims-20131120-2xvin.html> See also: ABC 7.30 Report (May 2013) '*Report reveals psychiatric care's shocking sexual assault statistics*'; at: <http://www.abc.net.au/7.30/content/2013/s3758227.htm>; See also: ABC 7.30 Report (December 2013) '*Protecting disabled people in group homes*'; at: <http://www.abc.net.au/7.30/content/2013/s3915884.htm>

<sup>145</sup> Committee on the Rights of Persons with Disabilities (2013) *Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session* (2-13 September 2013); UN Doc. CRPD/C/AUS/CO/1; Available at: [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FCO%2FAUS%2FCO%2F1&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FCO%2FAUS%2FCO%2F1&Lang=en)



65. These recommendations echo, and build on similar recommendations made to Australia in recent years from the *Committee on the Elimination of Discrimination Against Women* (CEDAW) (2010); the *Human Rights Council* (2011);<sup>146</sup> the *Committee on the Rights of the Child* (CRC) (2013);<sup>147</sup> and the *Committee on Economic, Social and Cultural Rights* (CESCR) (2012).<sup>148</sup> In addition, the *Commission on the Status of Women (CSW) Agreed Conclusions* (2013),<sup>149</sup> which the Australian government delegation helped to formulate and subsequently endorsed, acknowledge that women with disabilities are more vulnerable to all forms of violence, exploitation and abuse, and call on Governments the world over to prevent and address violence against women and girls with disabilities.
66. Provided as a formal attachment to this Submission, is a copy of the sentencing comments from a recent Australian court case, *DPP v Kumar* (20 November 2013), whereby a casual worker employed at a supported accommodation facility in Victoria, was sentenced to 18 years jail for multiple counts of rape and other sexual offences perpetrated against three disabled women and one disabled man. This document illustrates the nature of violence perpetrated against women and girls with disabilities in institutions, and is just one example of this widespread, unaddressed national issue. Although harrowing reading, the transcript highlights (amongst other things) the extreme powerlessness and vulnerability of women with disabilities in institutions, the lack of credibility they are given when trying to report violence, the existence of, and culture within institutions as breeding grounds for the perpetration of violence, and the tendency of staff and management to minimise and essentially cover up, acts of violence perpetrated against people with disabilities. It is highly likely that the main reason this particular case proceeded to a successful conviction was because the perpetrator pleaded guilty to the charges. Despite high levels of violence against women with disabilities in Australia, evidence shows that few cases are prosecuted. It has been well documented for decades that police are reluctant to investigate and report cases of violence against women with disabilities, particularly women with intellectual, cognitive, developmental, psychosocial disabilities.<sup>150</sup> This is in part due to the stereotypical perceptions of women with disabilities that have been found to be operating at almost all levels of the criminal justice system, including police and courts – ie: that women with disabilities are sexually promiscuous, provocative, unlikely to tell the truth, asexual, childlike, or unable to be a reliable witness.<sup>151</sup>
67. Comprehensive, inclusive and coherent human rights-based legislation is fundamental for an effective and coordinated response to violence against women and girls with disabilities. Australia has clear obligations under international human rights law to enact, implement and monitor legislation addressing all forms of violence against women and girls with disabilities, including those to which they are more vulnerable, such as forced sterilisation, forced institutionalisation and forced abortion.<sup>152</sup> This is important not only to ensure legal protection but also to promote a culture where no form of violence against women and girls with disabilities is tolerated.<sup>153</sup>
68. In Australia, there is no national, coordinated legislation to prevent and address all forms of violence against women, including family/domestic violence.<sup>154</sup> Legislation in federal and State and Territory jurisdictions sets the foundation for the rights of women to be protected against violence, and the States and territories carry primary responsibility for legislative measures to

<sup>146</sup> UN General Assembly, Human Rights Council (2011) OpCit.

<sup>147</sup> Committee on the Rights of the Child (2012) UN Doc. CRC/C/AUS/CO/4, OpCit.

<sup>148</sup> Committee on Economic, Social and Cultural Rights (2009) *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Australia*; 12 June 2009; UN Doc. E/C.12/AUS/CO/4

<sup>149</sup> UN Women (2013) *Elimination and Prevention of All Forms of Violence Against Women and Girls: 2013 Commission on the Status of Women Agreed Conclusions*. Available at: <http://www.unwomen.org/~media/Headquarters/Attachments/Sections/CSW/57/CSW57-AgreedConclusions-A4-en.pdf>

<sup>150</sup> WWDA (2007b) OpCit., See also: French, P. (2007) *Disabled Justice: The barriers to justice for persons with disability in Queensland*. Queensland Advocacy Incorporated (QAI), Brisbane. Accessed online October 2011 at: [http://www.qai.org.au/images/stories/docs/1987-2007/doc\\_199.pdf](http://www.qai.org.au/images/stories/docs/1987-2007/doc_199.pdf) See also: French, P., Dardel, J. & Price-Kelly, S. (2010) OpCit..

<sup>151</sup> WWDA (2007b) OpCit. See also: Healey, L., Howe, K., Humphreys, C., Jennings, C. & Julian, F. (2008) OpCit.

<sup>152</sup> United Nations General Assembly (2012) *Thematic study on the issue of violence against women and girls and disability: Report of the Office of the United Nations High Commissioner for Human Rights*. UN Doc. A/HRC/20/5.

<sup>153</sup> Ibid.

<sup>154</sup> Commonwealth of Australia (2012) *Information provided in follow-up to the concluding observations of the CEDAW Committee [Australia]*: Responses by Australia to the recommendations contained in the concluding observations of the Committee following the examination of the combined sixth and seventh reporting periodic report of Australia on 20 July 2010.

criminalise, prosecute and punish perpetrators for acts of domestic violence. According to the Australian Government:

*this foundation is augmented by a range of integrated support services.... which respond to the needs of women who have experienced violence at the time of crisis and recovery. All women in Australia have the protection of the law and the right to access support services. Every state and territory has enacted strong legislative measures and established competent tribunals and other law enforcement agencies to ensure the effective protection of women against any act of violence.....*<sup>155</sup>[emphasis added]

69. However, it is clear that women with disabilities In Australia do not enjoy the “*effective protection of women against any act of violence*”. There is no *specific* legal, administrative or policy framework for the prevention, protection, investigation and prosecution of violence, exploitation, and abuse of women with disabilities. No existing Commonwealth or State/Territory domestic and/or family violence is framed in a comprehensive human rights framework setting it in the context of Australia’s obligations to the core international human rights treaties it has ratified, each of which creates obligations to prevent and address violence against women, including women with disabilities.
70. The Commonwealth *Family Law Act 1975*, amended in 2011 through the *Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011*, contains no over-arching objects or principles, and is not set in a human rights framework. The only amendment made in 2011 relating to human rights was the inclusion of an object at sub section 60B (relating to children), which states “*an additional object of this Part is to give effect to the Convention on the Rights of the Child done at New York on 20 November 1989*”.<sup>156</sup>
71. The Australian Law Reform Commission (ALRC) in its 2010 *National Inquiry into Family Violence*,<sup>157</sup> recommended that Commonwealth, State, and Territory Family Violence legislation should contain guiding principles and objects that clearly reference a human rights framework, in order to: give effect to Australia’s international human rights obligations, serve as an educative function and aid in interpretation of the legislation. The principles should refer to or draw upon all applicable international human rights instruments.<sup>158</sup> In addition, human rights based family violence legislation should acknowledge the gendered-nature of violence<sup>159</sup> and that family violence has a particular impact on marginalised and vulnerable groups, including people with disabilities, Indigenous persons; those from a CALD background; those from the gay, lesbian, bisexual, transgender and intersex communities; and older persons. Yet most of the existing family violence legislation in Australia does not recognise all these dimensions. As pointed out by the ALRC:

*highlighting the impact of violence on these groups complements the Commissions’ recommendation that family violence legislation include examples of emotional or psychological abuse that would affect diverse groups in the community. The combined effect of these recommendations may assist in the challenging task of ensuring that experiences of family violence of such groups are properly recognised across the legal system.*

72. Without appropriate and inclusive legislation, there are limited legal means to fight violence against women with disabilities. Legislation has the potential to demonstrate that violence against women with disabilities is a public issue, not a private concern. In order to accomplish any appreciable reduction of violence against women with disabilities, it is necessary to understand its complexity. Causes, interventions and prevention strategies are contingent upon the validity of definitions available.<sup>160</sup> Definitions in family violence legislation are critical, because they set the

<sup>155</sup> Ibid.

<sup>156</sup> Family Law Act 1975, at sub section 60B. See at: [http://www.austlii.edu.au/au/legis/cth/consol\\_act/fla1975114/](http://www.austlii.edu.au/au/legis/cth/consol_act/fla1975114/)

<sup>157</sup> Australian Law Reform Commission (ALRC) (2010) *Family Violence — A National Legal Response*. ALRC Final Report 114. Accessed online January 2013 at: <http://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>

<sup>158</sup> Ibid.

<sup>159</sup> Ibid.

<sup>160</sup> WWDA (2007b) OpCit.

scope for who is covered by the legislation and under what circumstances. They also provide the benchmark for translation into relevant policy frameworks, policies and service responses.

73. In Australia, domestic and family violence legislation differs across States and Territories providing different levels of protection and definitions of what constitutes 'family violence' and what constitutes a 'domestic relationship'. Broader definitions include residential settings, such as group homes and institutions, where women with disabilities often live and interact domestically with co-residents, support workers and service managers.<sup>161</sup> However, even where there are broader definitions, domestic and family violence legislation is rarely utilised, largely because violence perpetrated against disabled women and girls in residential settings, as outlined earlier, is not characterised or conceptualised as domestic/family violence.<sup>162</sup> Where narrower definitions apply, women with disabilities who live in residential settings are entirely excluded from these protections.
74. The Commonwealth *Family Law Act 1975*, for example, provides non-exhaustive examples of what constitutes 'family violence' thereby providing scope to cover some of the forms of violence experienced by women and girls with disabilities. However, the examples provided in the Act are still relatively limiting for addressing the dimensions of domestic and family violence as experienced by women and girls with disabilities. For example, although the ALRC has interpreted the definition of family violence in the amended Act to include forced sterilisation and abortion,<sup>163</sup> it remains unclear as to whether the Act could or would be utilised to address these particular forms of violence. The definition of 'family member' and 'relative' in the amended *Family Law Act 1975* does not appear to be broad enough to encompass the range of 'domestic relationships' that many women with disabilities may be in, such those living in residential settings. The limiting definition does not cover paid and/or unpaid carers, which makes it problematic in providing protection and or redress for women with disabilities who experience domestic/family violence at the hands of carers.
75. Family violence legislation in some jurisdictions recognises violence between persons who live together in the same household (that is, without being in a relationship) as family violence. Other jurisdictions recognise meaningful personal relationships between people outside conventional definitions. Some legislation protects persons in carer relationships, including paid carers; some cover relationships with paid and unpaid carers as long as the relationship is 'family like'; whilst others cover unpaid carers only. Other family violence legislation, however (such as in Tasmania and Western Australia) does not address relationships with carers at all.<sup>164</sup> This is just one example that highlights the inconsistent approach taken in family violence legislation across Australia in relation to violence perpetrated against women and girls with disabilities.
76. It is clear that most family violence legislation in Australia is not set in a human rights framework, is piecemeal and inconsistent in definitions and scope, and focuses largely on protection from domestic/family violence. For women with disabilities, this means, in effect, that their experiences of violence, including domestic/family are not properly recognised across the legal system, they are given less protection than their non-disabled counterparts, and the likelihood of them benefiting from integrated and coordinated responses, including prevention, is compromised.
77. The *Committee on the Elimination of All Forms of Discrimination against Women* (CEDAW) has consistently expressed its concern at lack of federal legislation or minimum standards for protection of women against violence and domestic violence in Australia, and has repeatedly recommended that Australia develop national legislation to prevent and address violence against women, in all its forms.<sup>165</sup> Australia however, still does not have uniform, comprehensive, human rights based national legislation to prevent and address all forms of violence against women.

<sup>161</sup> 'Disability Rights Now' Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities; August 2012.

<sup>162</sup> Frohmader, C. & Swift, K. (2012) Opening minds & opening doors: Re- conceptualising 'domestic violence' to be inclusive of women with disabilities in institutions. *CDFVRe@der*, Vol. 11, No. 2, pp. 7-8. Available at: <http://www.noviolence.com.au/public/reader/readerdec2012.pdf>  
See also: 'Disability Rights Now' OpCit.

<sup>163</sup> Australian Law Reform Commission (ALRC)(2012) *Family Violence and Commonwealth Laws Information Sheet: People With Disability*; at: <http://www.alrc.gov.au/CFV-disability>

<sup>164</sup> Australian Law Reform Commission (ALRC) (2010) OpCit.

<sup>165</sup> Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7.



78. Accompanying this Submission are three specific documents which WWDA is formally submitting as attachments to WWDA's Submission to the *National Inquiry into Equal Recognition Before the Law and Legal Capacity for People With Disability*. These three documents are extremely relevant and timely for this National Inquiry, and they explore and detail a range of issues regarding equal recognition before the law and legal capacity for women with disabilities in relation to the right to freedom from violence, abuse, exploitation and neglect. These three documents are:

***Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper. Hobart: Women with Disabilities Australia.***

This background paper provides information on the National COAG Reform project 'Stop the Violence: Improving Service Delivery for Women and Girls with Disabilities'. This national Project, implemented by WWDA and supported by a research team at the University of New South Wales (UNSW) in conjunction with a project team from People with Disabilities Australia (PWDA), is intended to lay the groundwork for improved service provision by building the evidence-base for future reforms so that the service system is more responsive to the needs of women and girls with disabilities. The Background Paper provides information on the project context, activities and outcomes, highlighting six key issues and their implications that are considered a priority in addressing reform in the area of violence against women and girls with disabilities.

***Women With Disabilities Australia (WWDA), University of New South Wales (UNSW), and People with Disabilities Australia (PWDA) (2013) Report of the Proceedings and Outcomes of the National Symposium on Violence against Women and Girls with Disabilities. Hobart: Women with Disabilities Australia.***

The National Symposium on Violence against Women and Girls with Disabilities was part of the activities of the National COAG Reform project 'Stop the Violence Project (STVP)'. The purpose of the National Symposium was to engage high-level stakeholders and decision-makers to address issues of violence against women and girls with disabilities in Australia in order to develop measures for longer term sustainability for change relating to the National Plan to Reduce Violence against Women and their Children, 2010-2022. The National Symposium sought to foster collaborative approaches to policy development by strengthening cross-sector relationships and leadership for sustaining change in the identification and implementation of better practice models to prevent violence against women and girls with disabilities.

***Women With Disabilities Australia (WWDA) Submission to the United Nations Thematic Study on Violence Against Women With Disabilities (December 2011) Hobart: Women with Disabilities Australia.***

In mid June 2011, at its 17th session, the United Nations Human Rights Council adopted a Resolution to accelerate efforts to eliminate all forms of violence against women. The Resolution called for a study to be conducted on the issue of violence against women and girls and disabilities, with the report of the study to be presented to the 20th session of the Human Rights Council in 2012. WWDA's Submission to the preparation phase of the UN Analytical Study on Violence Against Women and Girls with Disabilities, provides an overview of the legislation, regulatory frameworks, policy, administrative procedures, services and support available within Australia to prevent and address violence against women and girls with disabilities. It provides detailed information under the following themes: data and statistics; legislation and policies; prevention and protection; prosecution and punishment, and recovery, rehabilitation and social integration.

## Case Examples

*A 39 year old woman with an intellectual disability resides in a group home 'village' complex where she has her own unit and lives independently which some support provided by the on site support worker staff. There are a number of other residents with intellectual disabilities living in other units on the site – some live in units on their own, whilst other share. The 39 year old woman is raped by a male co-resident within the grounds of the 'village' complex. She immediately discloses the rape to an on-site support worker who advises her to "try to keep out of his way" and that "if he does it again" the staff will "cut his penis off". The rape is not reported to the police and the woman is not offered any support or counselling.*

*A 38 year old woman with a mild intellectual disability lives on a farm in a rural and isolated location with her violent husband who is 20 years her senior. They have been married for three years. They have a 12 month old child who has been taken into care by authorities due to the ongoing family violence. Local police are aware of the violence and have visited the property on a number of occasions. The woman's husband tells the police his wife is "mental and retarded". The police do not intervene. The woman eventually decides to try to leave her husband and escapes during the night. She goes to a nearby country town where she has access to an unoccupied house owned by a relative. She seeks support via phone from a domestic violence outreach service, only to be told she can't get an appointment for 2 months. Her husband reports her to the police as a 'missing person' telling them she is not safe to be on her own because she has an intellectual disability. The police subsequently arrive at the house where she is staying, and take her back to her violent husband. She is not offered any alternative. She says: "The police don't believe me; they think I'm mental and he tells them I'm mental."*

*Linda is a 22 year old woman with a psychosocial and intellectual disability. She resides in a government funded group home with five other women with disabilities. Most of the other women are older – ranging in age between 40-60 years. The organisation managing the group home also runs several other group homes in the area. Linda is told by the support workers that she is being taken to visit "Jack" – a young man with an intellectual disability who resides in one of the other group homes run by the organisation. Jack is considered to have significant 'behavioural issues' and is 'difficult for staff to manage'. Jack is considered easier to 'manage' if he is not 'sexually frustrated'. Linda is told by the support workers that Jack is her "boyfriend". Linda is taken to the group home where Jack resides and sent into his bedroom. Linda is raped by Jack but Linda thinks that she has to let Jack have sex with her (even though she doesn't want to) because she has been told that Jack is her "boyfriend". This 'arrangement' continues for many months until Linda eventually discloses to a neighbour that Jack "hurts her" when he makes her have sex. Linda shows her neighbour the cuts and bruises on her genitalia and inner thighs. Linda is eventually taken to a sexual assault support service, accompanied by an independent advocate. After one session, the sexual assault support service says they can no longer assist, because Linda won't "open up" to them, and they don't have the resources or the capacity to work with her.*

## The Right to Found and Maintain a Family

---

79. Although the right to ‘found a family’ and to ‘reproductive freedom’ is clearly articulated in a number of international human rights instruments to which Australia is a party,<sup>166</sup> for many women with disabilities in Australia, such fundamental human rights are not realisable.
80. Parenting remains an attitudinal minefield for women with disabilities and an area in which they experience widespread violations of their human rights. Women with disabilities the world over are discouraged or denied the opportunity, to bear and raise children.<sup>167</sup> The situation in Australia is no different. Women with disabilities have been, and continue to be perceived as asexual, dependent, recipients of care rather than care-givers, and generally incapable of looking after children.<sup>168</sup> Alternatively, women with intellectual disabilities in particular may be regarded as overly sexual, creating a fear of profligacy and the reproduction of disabled babies, often a justification for their sterilisation.<sup>169</sup> These perceptions, although very different, result in women with disabilities being denied the right to reproductive autonomy and self-determination.
81. Recent data demonstrates that a parent with a disability (usually a mother) is up to ten times more likely than other parents to have a child removed from their care, with the child removed by authorities on the basis of the parents disability, rather than any evidence of child neglect.<sup>170</sup> Women with disabilities are also coerced to have hysterectomies after they have given birth to one or more children, who have usually been taken from their care; or as a condition of having access to their child who has been taken from their care.<sup>171</sup>
82. Fears of women with disabilities as parents persist although evidence demonstrates that parents with disabilities are no more likely to maltreat children or to raise so-called “defective” children than non-disabled parents.<sup>172</sup> Statutes in many countries on termination of parental rights, child custody and divorce include disability-related grounds for termination of parental rights or loss of custody and may emphasise and focus on disability status rather than actual parenting skill or behaviour, implicitly equating parental disability with parental unfitness.<sup>173</sup> Because of such legal definitions and societal prejudices, mothers with disabilities are often subjected to greater scrutiny by social service agencies than non-disabled women. Fear of being incorrectly perceived as an unfit mother by a court on the basis of disability, and the breakdown of their relationship with children, has frequently discouraged mothers with disabilities from separating from an abusive partner.<sup>174</sup>
83. A recently released report<sup>175</sup> by the Victorian Office of the Public Advocate (OPA) which examines the removal of children from the care of parents with a disability through the family law system, asserts that in relation to people with disabilities and their right to parent, current policy in Australia appears to be based on the following broad propositions:
- people with disabilities cannot be competent parents;
  - it is rarely in the best interests of a child to be raised by parents with a disability;

---

<sup>166</sup> See for eg: International Covenant on Economic, Social and Cultural Rights (Article 10); International Covenant on Civil and Political Rights (Article 23); Convention on the Elimination of All Forms of Discrimination against Women (Article 16); Convention on the Rights of Persons with Disabilities (Article 23).

<sup>167</sup> Women With Disabilities Australia: ‘Parenting Issues for Women with Disabilities in Australia’ - A Policy Paper (May 2009). Available at: [www.wdda.org.au/motherhd2006.htm](http://www.wdda.org.au/motherhd2006.htm)

<sup>168</sup> Ibid.

<sup>169</sup> WWDA (2007b) OpCit.

<sup>170</sup> This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child’s extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/>

<sup>171</sup> People With Disabilities Australia (PWDA) (2013) *Submission to the Senate Standing Committee on Community Affairs: Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia*. See: [www.pwd.org.au](http://www.pwd.org.au)

<sup>172</sup> UN General Assembly, Secretary General (2012) *Report of the Special Rapporteur on violence against women, its causes and consequences*. UN Doc No. A/67/227.

<sup>173</sup> See: Disability and Parental Rights Legislative Change Project, ‘Guide for Creating Legislative Change’; University of Minnesota, <http://www.cehd.umn.edu/ssw/CASCW/attributes/PDF/LegislativeChange.pdf>

<sup>174</sup> Frohmader, C. & Ortoleva, S. (2013) OpCit.

<sup>175</sup> Office of the Public Advocate (December 2013) *Whatever happened to the village? The removal of children from parents with a disability*. Report 1: Family law – the hidden issues. OPA, Victoria.

- if a case has been made for removal of a child, then alternative care is seen as better for the child and a less risky solution for the child and for the decision-maker. It also requires no follow-up supervision;
  - a child is an individual bearer of rights whose rights and interests are not necessarily embedded within his or her family;
  - within both family law and child protection legislation and policy in Australia, only the child who is the subject of the application has rights. Parents have duties and responsibilities. Siblings who are not the subject of the application do not have rights and their interests are only relevant to the extent that they concur with those of the child who is the subject of the application;
  - the impact on a family of removing a child from his/her parents is not a consideration in family law or child protection legislation and practice and is not a factor in deciding the best interests of the child in either jurisdiction.
84. The OPA Report includes a series of recommendations calling for significant reforms to be made to the Commonwealth Family Law Act (1975), family law policy and practice that would assist Australia to comply with the conventions to which it is signatory in relation to parents with a disability and their children in family law.<sup>176</sup>
85. Although there is no known published research in Australia on the issue of access to assisted reproductive technologies (ARTs) (such as in vitro fertilisation (IVF) and assisted insemination) for women with disabilities, anecdotal information to Women With Disabilities Australia (WWDA) from women with disabilities in Australia suggests that they face discrimination and inequitable access to ART's.
86. The predominance of white, middle class, able-bodied women living as heterosexual couples is evident across private IVF clientele. This is, in part, due to the costs to the client associated with the procedure.<sup>177</sup> In Australia, Medicare covers the treatment of IVF for medical infertility, but for women who are deemed not to be 'medically infertile' (such as single women and lesbian couples), then no Medicare rebate is available. This fact alone would prevent many disabled women (particularly single disabled women, or women with disabilities who are in a lesbian relationship) from accessing ART's.
87. There is no Commonwealth legislation in respect of ART practice. In Australia, the eight State and Territory governments control assisted reproduction services, with SA, NSW, VIC, and WA having enacted legislation to control the procedures involved (although the nature of the governance regimes in each of these states varies), while the States and territories without specific legislation rely on the Reproductive Technology Accreditation Committee accreditation scheme which sets standards for practice and requires compliance with the National Health and Medical Research Council (NHMRC) *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2007).<sup>178</sup> These guidelines, revised in 2007, effectively ignore access and eligibility issues by failing to address them. Instead, the guidelines recommend that each assisted reproduction clinic should develop a 'protocol' around access to, and eligibility for, treatment. Whilst some individual clinics specify that assisted reproductive treatment procedures are not denied to women on the basis of marital status or sexual orientation, none mention disability. The decision for eligibility for assisted reproductive services therefore rests with the individual clinics/fertility consultants.
88. In 2007, the Victorian Law Reform Commission (VLRC) released its final report on ART and adoption.<sup>179</sup> The VLRC had been commissioned by the Victorian Government to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* [Vic] and the *Adoption Act 1984* [Vic] to expand eligibility criteria in respect of all or any forms of assisted

<sup>176</sup> Ibid.

<sup>177</sup> Petersen, M. M. (2005) Assisted reproductive technologies and equity of access issues; *Journal of Medical Ethics*; 31; pp. 280-285.

<sup>178</sup> National Health and Medical Research Council (NHMRC) (2004) (Revised 2007) *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research*. NHMRC, Canberra, ACT.

<sup>179</sup> Victorian Law Reform Commission (VLRC) (2007) *Assisted Reproductive Technology & Adoption: Final Report*. Victorian Law Reform Commission, Melbourne, Victoria.

reproduction and adoption. In relation to access to assisted reproductive technology, the VLRC decided:

*“not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child”.*

The resulting amended legislation, renamed the *Assisted Reproductive Treatment Bill 2008*, omits disability from its non-discrimination clause: ‘persons seeking to undergo treatment procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion’.<sup>180</sup> In practice, this means that women with disabilities could be discriminated against on the basis of disability if seeking to access ART in Victoria.

### Case Examples

*Lucy has been married for five years to her husband who is 25 years her senior. Lucy’s husband has been married before and has children from two former relationships. Lucy’s husband has a long history of violence, including domestic violence, and has been imprisoned in the past for violence offences and breach of Apprehended Violence Orders. Lucy and her husband have a three year old daughter. Lucy has a past history of mental illness but has been non-episodic for more than 10 years. The marriage eventually breaks down due to the domestic violence perpetrated against Lucy by her husband. A custody dispute ensues. The Court awards full custody of the child to Lucy’s husband, on the grounds that Lucy has a “mental illness”. Lucy spends the next 12 years fighting to get her daughter back, to no avail.*

*A 40 year old woman with a psychosocial disability goes into labour and is in the labour ward of a public hospital about to give birth to her first child. She has been having difficulty stabilising her disability during her pregnancy, as she has been unable to take her standard medications due to the potential effect on the unborn child. Whilst she is giving birth, a senior nurse involved in her care makes an urgent phone call to WWDA. The nurse asks for urgent help. She advises WWDA that authorities have already made the decision to remove the child from the mother, as soon as the child is born. She says the paperwork is all done and the hospital social worker is no help, because she supports the removal of the child from her mother. The nurse advises that the woman has not been told and has no idea that her child is to be taken from her as soon as it is born. The nurse says she didn’t know who else she could ring for help. WWDA makes a series of calls to seek urgent intervention. The Office of the Public Advocate is able to assist and intervenes.*

*Jasmine is 21 years old. She and her husband both have a mild intellectual disability, and both are Aboriginal. Jasmine and her husband decided they wanted to have a child, and Jasmine soon became pregnant. Jasmine’s pregnancy was uneventful, and she gave birth to a healthy baby girl, Tameka. Four days after Tameka was born, child welfare authorities arrived at the hospital and removed her from her parents care. Jasmine, her husband, and their parents (Tameka’s grandparents) had been given no indication that Tameka was going to be removed by child welfare authorities. It was almost a month later that Jasmine and her family were told why Tameka had been removed. The reasons given were that Jasmine had a past history of mental health issues (which had been undiagnosed until not long before her pregnancy when she was finally diagnosed with a specific type of mental health impairment*

---

<sup>180</sup> [Victoria] *Assisted Reproductive Treatment Bill 2008* (Part 1, 5, p.8).

*and subsequently stabilised with medication). Other reasons given were that Jasmine had displayed 'poor parenting skills' and that she was deliberately 'starving her baby'. In actual fact, Jasmine's relatives advised that she had experienced severe difficulties with breastfeeding her baby, had repeatedly asked for guidance and help from the nurses, but had either been ignored or told to 'just persist'. A lawyer was engaged by Jasmine's mother and father to have Tameka returned to her parents care. Although the lawyer felt that this was a clear case of disability discrimination and that the allegations could easily be proven as false, the lawyer warned it could take up to a year for the case to be resolved. Jasmine and her husband are now only able to see their daughter twice a week for an hour at a time. These visits are supervised and Jasmine's relatives also believe that the sessions have been secretly video taped with smart phones. Jasmine's great grandmother was part of the Stolen Generation.*

## The Right to Work

---

89. Women with disabilities in Australia are significantly disadvantaged in employment in relation to access to jobs, in regard to remuneration for the work they perform, and in the types of jobs they gain. Working-age women with disabilities who are in the labour force are half as likely to find full-time employment (20%) as men with disabilities (42%); twice as likely to be in part-time employment (24%) as men with disabilities (12%); and regardless of full-time or part-time status, are likely to be in lower paid jobs than men with disabilities.<sup>181</sup> A 2004 *Senate Inquiry into Poverty and Financial Hardship* concluded that women with disabilities are also affected by the lower wages paid to women relative to men and are more likely to be in casual jobs with little job security.<sup>182</sup>
90. Although the *National Disability Strategy* recognises that women with disabilities ‘face poorer economic outcomes than men with disabilities’, the Strategy contains no gender-specific measures to address this disparity.
91. In 2009 the Parliament of the Commonwealth of Australia undertook a national inquiry into Pay Equity and associated issues relating to female participation in the workforce. The Report of the Inquiry ‘*Making It Fair*’<sup>183</sup> recommended, amongst other things that ‘*the Government as a matter of priority collect relevant information on workforce participation of women with disabilities to provide a basis for pay equity analysis and inform future policy direction.*’ This recommendation has never been enacted.
92. In October 2013, the *Committee on the Rights of Persons with Disabilities* in its Concluding Observations following its Review of Australia’s compliance with the CRPD, recommended that the Australian Government:

*‘adopt initiatives to increase employment participation of women with disabilities by addressing the specific underlying structural barriers to their workforce participation’.*<sup>184</sup>

93. In 2010, the UN CEDAW Committee expressed its concern at the continued disadvantage experienced by women with disabilities with regard to educational and employment opportunities; including the limited access to job opportunities for disabled women. The Committee recommended, both in its 2006 and 2010 Concluding Observations [Australia] that:

*‘the State Party adopt urgent measures to ensure that women with disabilities are better represented in decision-making and leadership positions, including through the adoption of temporary special measures such as quotas and targets, in accordance with article 4, paragraph 1 of the Convention and the Committee’s general recommendation No. 25.’*

These recommendations have not been taken up by the Australian Government, and disabled women continue to experience marginalisation and exclusion in the Australian labour market – a situation that has remained unchanged for more than two decades.<sup>185</sup>

---

<sup>181</sup> Australian Bureau of Statistics, ‘*Labour Force Characteristics of People with a Disability*’ in *Year Book Australia* (2006); Sue Salthouse, ‘*Jumping Through Hoops — Welfare and Industrial Relations Reform Implications for Women with Disabilities*’ (Paper presented at the What Women Want Workshop — A Workshop on the Effect of the Federal Government’s Recent Policy Changes on Women of Working Age, Canberra, 12 July 2005) [www.wda.org.au/w2wjuly05.htm](http://www.wda.org.au/w2wjuly05.htm).

<sup>182</sup> In ‘Disability Rights Now’ OpCit.

<sup>183</sup> Commonwealth of Australia (2009) *Making it Fair: Pay equity and associated issues related to increasing female participation in the workforce*. Report of the House of Representatives Standing Committee on Employment and Workplace Relations. Accessed online December 2012 at:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=ewr/payequity/report.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ewr/payequity/report.htm)

<sup>184</sup> Committee on the Rights of Persons with Disabilities (2013) *Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session* (2-13 September 2013); UN Doc. CRPD/C/AUS/CO/1; Available at:

[http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FAUS%2FCO%2F1&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FAUS%2FCO%2F1&Lang=en)

<sup>185</sup> UN Committee on the Elimination of Discrimination against Women, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Australia*, 3 February 2006, CEDAW/C/AUL/CO/5.



94. Successive Australian Governments have increased focus on getting people with disabilities into employment, including into open employment and/or supported employment. The current Federal Government has signalled its intent to reduce the number of persons on 'welfare', including those in receipt of the Disability Support Pension (DSP). Whilst WWDA supports initiatives that enable women with disabilities to find, secure and maintain meaningful employment, WWDA remains deeply concerned at the high incidence of violence, abuse, exploitation, bullying and harassment perpetrated against women with disabilities in the workplace. There would appear to be no national policy response to this widespread issue. Commonwealth Government funded initiatives (such as the Job Access Program) fail to address violence and abuse (including sexual violence) perpetrated against women with disabilities in employment settings. Disability Employment Services (DES), funded by the Federal Government and which are one of the primary mechanisms to get people with disabilities into the workforce, are required to comply with the Disability Services Standards, which contain a standard on 'Protection of human rights and freedom from abuse'. In reporting against this Standard, funded agencies 'may provide evidence' that staff have the knowledge to 'report criminal activities, abuse and neglect', and can provide 'practical examples of how they act to prevent abuse and neglect'.<sup>186</sup> As a mechanism to prevent and address violence against women and girls with disabilities, the Disability Services Standards are grossly ineffective. They are un-gendered, they focus only on 'abuse and neglect', they rely on service providers possessing the knowledge of what constitutes violence against women and girls with disabilities, they are essentially adult focused, and are concerned primarily with the collection of quantitative data.

### Case Examples

*Fran is a young woman in her mid 20's. Fran has a cognitive disability. She has always wanted a job that pays her proper wages and that is interesting. She hasn't ever had much success at getting a job. She finally gets some help from a Disability Employment Service (DES), which finds her a job in open employment. Fran is over the moon. The DES support worker visits Fran at work every few weeks to see how she is getting on. Fran loves her job and for the first few months everything goes well. Over a period of several weeks, Fran's demeanour changes. She appears withdrawn and sad. She is having trouble sleeping and suddenly won't go to bed without the lights on. Fran finally discloses to her DES support worker, that she is being repeatedly raped in the workplace by an employee. The perpetrator told Fran that if she told anyone she would get into lots of trouble and would lose her job. Fran's parents are notified and they call in the police. An investigation commences. The manager of the company where Fran works thinks Fran might be 'making it up'. He suggests that Fran might not be able to accurately identify the perpetrator, that she might 'inadvertently get him mixed up with someone else'. Already, seeds of doubt are being sown about Fran's credibility. Fran's parents decide that they will not access advocacy support to go through the police investigation process. They want to do it on their own. Fran doesn't get a choice about this. Fran's parents ask the DES support worker where they can access specialist counselling support for the daughter. The DES worker doesn't know. WWDA is contacted for help. WWDA sources and organises a sexual assault crisis support service for Fran and her family. The police investigation continues.*

*Mia is 40 and lives in a regional and remote area of Australia. Mia is desperate to work in paid employment. She loves working and feels she has a lot to contribute. She stayed in her last job for 10 years and was a highly valued employee. She only left her job because her [then] partner had secured a good job in regional Australia. Mia has a disability which affects her vision at times, however, with appropriate aids and equipment, she is a productive employee. Mia has difficulty finding a job in her new area. She seeks the help of a Disability Employment Service (DES), which helps her to apply for a job in a call centre. At interview, Mia advises the manager that she has a disability which affects her vision but that*

---

<sup>186</sup> Department of Families, Housing, Community Services & Indigenous Affairs (FaHCSIA) (2011) *Disability Services Standards Self-Assessment Guide*; National Disability Advocacy Program. FaHCSIA, Canberra.



*it will not affect her work performance. Mia gets the job. Mia requests an orientation to her new job, but the Manager says she doesn't have time and Mia will just have to figure it out. Within days of commencing her new job, Mia starts to experience bullying from the Manager. Mia is placed in a dark corner of the office space where she has difficulty seeing. She is given a chair that doesn't allow her to get close enough to the desk to see the computer screen. Mia's request for minor adjustments to her work station (including a light) are denied by the Manager. The discrimination intensifies. Mia is frightened of going to work but she wants to keep her job and doesn't understand why she is being treated so cruelly. Mia doesn't take any time off, despite her doctors concerns at the effect the discrimination is having on her. Mia keeps her DES support worker updated about all the incidents she is experiencing. Her DES support worker agrees Mia is experiencing disability discrimination but says there is nothing that she or the DES can do about it. One day Mia goes to work and is introduced to a young man who has been employed by the Manager. He is in the process of receiving an orientation from the Manager. Later that day, Mia is told by the manager that she is being sacked. Mia is not given any reasons why her employment is being terminated. She is given one day's notice. When Mia advises her DES support worker what has happened, the DES worker re-iterates that there is nothing the DES can do about it. The DES worker gives Mia WWDA's phone number and tells her to contact WWDA to see if WWDA can help her. WWDA is able to find Mia a solicitor who is currently working with Mia to lodge a formal disability discrimination complaint against the call centre.*

## The Right to Participate in Political and Public Life

---

95. Participation of women with disabilities as citizens is at the basis of the recognition of their dignity. For women and girls with disabilities, participation in social and political life and ensuring an adequate standard of living depends on their access to fundamental social structures such as education, employment, health care, housing, and free enjoyment of the most fundamental human rights, such as the right to sexuality and reproduction and freedom from all forms of violence. However, regardless of country or culture, disabled women and girls all over the world, do not have access to the social structures to enable them to enjoy their human rights. Many are denied the most fundamental rights and freedoms to enable their participation in social and political life on an equal basis as others. They are not treated with dignity and respect, they remain profoundly more disadvantaged than their male counterparts; and are systematically denied opportunities to develop, gain an education and live a full and meaningful life. Instead, they continue to experience multiple forms of discrimination, and widespread, serious violation of their human rights.<sup>187</sup>
96. Access to decision-making, political participation and representation are essential markers of gender equality. Although there has been progress in women's participation in decision-making globally, the participation of women with disabilities in all areas of public life in Australia remains woefully inadequate. Women and girls with disabilities in Australia are often excluded from, and denied opportunities to participate in decision-making about issues that affect their lives and those of their families, community and nation.
97. Australia has clear obligations under the international human rights treaties it has ratified, including CEDAW and the CRPD, to ensure the active, free, informed and meaningful participation of women and girls with disabilities at all stages of the design, implementation, monitoring and evaluation of decisions and policies affecting them, including for example, those relating to sexual and reproductive rights, and prevention of violence. This requires capacity-building and human rights education for women and girls with disabilities, and the establishment of specific mechanisms and institutional arrangements, at various levels of decision-making, to overcome the obstacles that women and girls with disabilities face in terms of effective participation.
98. The empowerment of women with disabilities is achieved principally through women with disabilities coming together to share their experiences, gaining strength from one another and providing positive role models. Women and girls with disabilities, their representative organisations and networks, must be empowered with sufficient resources, training and opportunities to effectively participate in shaping and monitoring the policies that affect them, at the national, regional and international levels.
99. Organisations and groups of women with disabilities play a critical role in raising awareness of, and working to address the violations, denials and infringements of their human rights. In Australia, WWDA is the only national representative civil society organisation (CSO) for women and girls with disabilities, but with a total workforce of one paid employee and an annual budget of \$163,000, WWDA's capacity to promote the participation and inclusion of disabled women and girls, is obviously significantly hampered. Financial and political support is therefore urgently needed for the establishment and maintenance of organisations, groups and networks of women with disabilities at the national and state/territory levels.
99. Fulfilling the right to information is a key prerequisite for the active, free, informed, relevant and meaningful participation of women and girls with disabilities. Yet many women and girls with disabilities are denied the right to seek, receive and impart information about decisions affecting their lives. They are far less likely than their non-disabled counterparts to receive general information or information that is gender and disability-specific, particularly relating to issues such as sexual and reproductive rights, and prevention of violence. They are denied access to information as to how their human rights and freedoms can be enforced and violations remedied. Women with disabilities have limited, if any, input into the development of relevant policies, services and programs, including information and education resources.

---

<sup>187</sup> Frohmader, C. (2013) OpCit.

100. The *Committee on the Rights of Persons with Disabilities* (CRPD), in its *Concluding Observations (Australia)*, released in October 2013, expressed its regret at the lack of mechanisms for consultation and engagement between Government and persons with disabilities and their organisations in all matters of Convention policy development and legislative reform, and recommended that:

*the State party, in partnership with persons with disabilities through their representative organisations, establish engagement mechanisms for ensuring meaningful participation in the development and implementation of legislation and policies to implement the Convention.*

101. The Committee has also recommended that the State party take initiatives to increase the resources available for independent organisations of persons with disabilities (including organisations representing children with disabilities) in order enable meaningful participation, consultation and engagement between Government and persons with disabilities.<sup>188</sup>

102. The CRPD Committee further recommended that Australia:

*take immediate steps to replace substitute decision-making with supported decision-making and provide a wide range of measures which respect the person's autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual's right, in his/her own capacity, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, and to work.*<sup>189</sup>

103. In addition, the CRPD Committee expressed its concern that Australia lacks a participatory and responsive structure for the implementation and monitoring of the Convention in line with Article 33, and recommended the State party immediately set up a monitoring system that would be fully in line with the provisions of Article 33 of the Convention.<sup>190</sup>

104. Furthermore, the CRPD expressly recommended that Australia:

*commissions and funds a comprehensive assessment of the situation of girls and women with disability, in order to establish a baseline of disaggregated data against which future progress towards the Convention can be measured.*<sup>191</sup>

105. The CEDAW Committee in both its 2006 and 2010 *Concluding Observations [Australia]* has expressed its concerns at the slow progress in ensuring the equal participation of women with disabilities in leadership and decision-making positions, in public and political life as well as their equal access to education, employment and health. The CEDAW Committee has re-iterated that the measures taken by the Australian Government to enhance the participation of women with disabilities in public life remains inadequate. The Committee continues to be concerned that Australia does not favour adoption of temporary special measures in the form of compulsory targets and quotas to address the under- representation of women with disabilities in decision-making bodies, in political and public life and the persistent inequality of their access to education, employment opportunities and health care services. The CEDAW Committee has also explicitly recognised that violence against disabled women and girls, and denial of their sexual and reproductive rights, severely limit the opportunities for the participation of women and girls with disabilities in public life. In so doing, the Committee has called on the Australian Government to address these issues.

---

<sup>188</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations on the initial report of Australia*. Adopted by the Committee at its tenth session (2–13 September 2013); 4th October 2013; UN Doc. CRPD/C/AUS/CO/1.

<sup>189</sup> Ibid.

<sup>190</sup> Ibid.

<sup>191</sup> Ibid.



Women  
With  
Disabilities  
Australia  
(WWDA)

# DEHUMANISED

**THE FORCED STERILISATION  
OF WOMEN AND GIRLS WITH  
DISABILITIES IN AUSTRALIA**



# DEHUMANISED

## **'DEHUMANISED: THE FORCED STERILISATION OF WOMEN AND GIRLS WITH DISABILITIES IN AUSTRALIA'**

WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia

*By Carolyn Frohmader for Women With Disabilities Australia (WWDA)*

© Women With Disabilities Australia (WWDA) March 2013

ISBN 978-0-9876035-0-0

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without written permission from Women With Disabilities Australia (WWDA). All possible care has been taken in the preparation of the information contained in this document. WWDA disclaims any liability for the accuracy and sufficiency of the information and under no circumstances shall be liable in negligence or otherwise in or arising out of the preparation or supply of any of the information aforesaid.

This publication has been prepared by Women with Disabilities Australia Inc. for the Australian Government, represented by the Department of Families, Housing, Community Services and Indigenous Affairs. The views expressed in this publication are those of Women with Disabilities Australia Inc. and do not necessarily represent the views of the Australian Government.

### **ABOUT WOMEN WITH DISABILITIES AUSTRALIA (WWDA)**

Women With Disabilities Australia (WWDA)<sup>1</sup> is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA's work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the reproductive rights of women and girls with disabilities, along with promoting their rights to freedom from violence and exploitation, and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.<sup>2</sup>

### **WOMEN WITH DISABILITIES AUSTRALIA (WWDA)**

PO Box 605, Rosny Park 7018 Tasmania, Australia

**Ph** +61 3 62448288

**Fax** +61 3 62448255

**Email** [wwda@wwda.org.au](mailto:wwda@wwda.org.au)

**Web** [www.wwda.org.au](http://www.wwda.org.au)

**Facebook** [www.facebook.com/WWDA.Australia](http://www.facebook.com/WWDA.Australia)

Winner, National Human Rights Award 2001

Winner, National Violence Prevention Award 1999

Winner, Tasmanian Women's Safety Award 2008

Certificate of Merit, Australian Crime & Violence Prevention Awards 2008

Nominee, French Republic's Human Rights Prize 2003

Nominee, UN Millennium Peace Prize for Women 2000





# CONTENTS

<b>Acknowledgment</b>	<b>5</b>
<b>Overview</b>	<b>7</b>
<b>Key Recommendations</b>	<b>13</b>
<b>Terminology</b>	<b>21</b>
<b>Background and Status of the Issue in Australia</b>	<b>24</b>
<b>Rationale Used to Justify Forced Sterilisation in Australia</b>	<b>35</b>
The Genetic/Eugenic Argument	36
For the Good of the State, Family and/or Community	38
Incapacity for Parenthood	43
Incapacity to Develop and Evolve	45
Prevention of Sexual Abuse	47
The 'Best Interest' Argument	53
<b>The Impact</b>	<b>58</b>
<b>Forced Sterilisation as a Violation of Human Rights</b>	<b>69</b>
The Convention on the Rights of Persons With Disabilities	71
The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	73
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	75
The International Covenant on Civil and Political Rights (ICCPR)	78
The Convention on the Rights of the Child (CRC)	79
The International Covenant on Economic, Social and Cultural Rights (CESCR)	80
The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	84
Other Key International and National Standards and Frameworks	85
Other Legal Precedents	86
<b>Redress &amp; Transitional Justice</b>	<b>88</b>
<b>Conclusion</b>	<b>96</b>
<b>Footnotes</b>	<b>98</b>

# ACKNOWLEDGEMENT

In presenting this Submission to the Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia, WWDA wishes to acknowledge and thank all the women who have been involved with Women with Disabilities Australia (WWDA).

We dedicate this work to all those who have suffered discrimination and the devastating life-long impact of forced or coerced sterilisation and other violations of their reproductive health rights. Although we can never take away the pain and trauma of those women and girls affected, we trust that our work will ensure that this gross violation of the human rights of women and girls with disabilities will never be allowed to occur again.

To our sisters in other countries who are also continuing the fight to stop the practice of forced and coerced sterilisation of women and girls, we hope our work can contribute in some small way to your efforts.

"I think there should be an Act that should go through Parliament, it must be a Sterilisation Act that stops girls and women with intellectual disabilities being sterilised."

**PARTICIPANT, STAR CONFERENCE ON STERILISATION, 1990<sup>3</sup>**





# OVERVIEW

# OVERVIEW

1. Australia is a country that prides itself on values and principles which provide the basis for a free and democratic society, including for example: the equal worth, dignity and freedom of the individual; equality under the law; equality of opportunity; equality of men and women; and the right of its citizens to participate fully in the economic, political and social life of the nation.<sup>4</sup> However, these entitlements remain a distant goal for many women and girls with disabilities. In contemporary Australia, many are denied the most fundamental rights and freedoms, they are not treated with dignity and respect, they remain profoundly more disadvantaged than their male counterparts; are systematically denied opportunities to develop, gain an education and live a full and meaningful life. They experience multiple forms of discrimination, and widespread, serious violation of their human rights.
2. Denial of these rights and freedoms is predicated on the assumption - usually implicit - that there are degrees of being human, and that only the “fully human” are entitled to enjoy the advantages of our society and the full protection of its laws. Since ability and intelligence are highly valued in our society, they are closely associated with being human. ‘Diminished ability and intelligence’, on the other hand, is equated with lower forms of life. Women with disabilities have typically been perceived as sub-human - lacking such basic human needs as the need for love, intimacy, identity and freedom. Dehumanising conditions - such as those which still pervade many of our state institutions - have been rationalised on the basis that women with disabilities do not have the same needs and feelings as the “fully human”, and hence that they do not need privacy, personal property, recognition, intimacy or freedom of choice. Viewed as “undesirable” and as potential threats to society, women with disabilities have often been isolated in institutions and otherwise prevented from fully participating in society.<sup>5</sup>
3. The right to bodily integrity and bodily autonomy, including the right of a woman to make her own reproductive choices, are enshrined in a number of international human rights treaties and instruments to which Australia is a party. However, women and girls with disabilities in Australia have failed to be afforded, or benefit from, these provisions in international human rights law. Instead, systemic prejudice and discrimination against them continues to result in widespread denial of their right to make decisions about their own bodies, experience their sexuality, have sexual relationships, and found and maintain families. In Australia there are women and girls with disabilities who have been and continue to be, denied these and other fundamental human rights through the ongoing Government sanctioned practice of ‘forced/involuntary’ and ‘coerced’ sterilisation.<sup>6</sup>
4. Forced sterilisation – that is, sterilisation in the absence of the free and informed consent of the individual concerned - including instances in which sterilisation has been authorised by a third party, without that individual’s consent<sup>7</sup> - is an act of violence,<sup>8</sup> a form of social control, and a clear and documented violation of the right to be free from torture.<sup>9</sup> Forced sterilisation of girls and women with disabilities is internationally recognised as a harmful practice based on tradition, culture, religion or superstition.<sup>10</sup> Perpetrators<sup>11</sup> are seldom held accountable and women and girls with disabilities who have experienced this violent abuse of their rights are rarely, if ever, able to obtain justice. Successive Australian Governments have not acknowledged this pervasive practice, nor expressed regret, nor offered redress to the women and girls affected.

# OVERVIEW

5. Forced sterilisation constitutes torture.<sup>12</sup> The right to be free from torture is one of the few absolute and non-derogable human rights, a matter of *jus cogens*,<sup>13</sup> a peremptory norm of customary international law, and as such is binding on all States, irrespective of whether they have ratified specific treaties.<sup>14</sup> A State cannot justify its non-compliance with the absolute prohibition of torture, under any circumstances. The UN Special Rapporteur on Torture has recently clarified:

“Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.”<sup>15</sup>

“Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.”<sup>15</sup>



# OVERVIEW

6. Forced sterilisation breaches every international human rights treaty to which Australia is a party. Legal authorisation of forced sterilisation procedures directly implicate the Australian Government in the perpetration of torture against disabled women and girls. Any law which authorises forced sterilisation is a law which authorises violence against women, the consequence of which is severe pain and suffering,<sup>16</sup> including *'drastic and emotionally painful consequences that are un-ending'*.<sup>17</sup>
7. The UN Special Rapporteur on Torture has made it clear that the failure of the State to exercise due diligence to intervene to prevent torture and provide remedies to victims of torture *'facilitates and enables non-state actors to commit acts impermissible under [the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment] with impunity,'* and its indifference or inaction provides a form of encouragement and/or de facto permission.<sup>18</sup> The UN Committee Against Torture has also confirmed that States have a heightened obligation to protect vulnerable and/or marginalised individuals from torture and cruel inhuman and degrading treatment and to:

*'adopt effective measures to prevent public authorities and other persons acting in an official capacity from directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in acts of torture.'*<sup>19</sup>

8. For more than twenty years, women with disabilities and their allies have been demanding successive Australian Governments show national leadership and undertake wide ranging reforms to stop the forced and coerced sterilisation of women and girls with disabilities, and develop policies and programs that enable disabled women and girls to realise their human rights on an equal basis as others. These recommendations to the Australian Government for action have been strongly echoed, supported and re-iterated by several international human rights treaty monitoring bodies and mechanisms since 2005.<sup>20</sup> That Australian Governments have chosen to ignore the voices of disabled women, as well as clear recommendations from the United Nations and international medical bodies, clearly demonstrates that disabled women and girls are not considered by our Governments as worthy of all that it means to be fully human.
9. No group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights, as women with disabilities.<sup>21</sup> The practice of forced sterilisation is itself part of a broader pattern of denial of human and reproductive rights of Australian disabled women and girls which also includes systematic exclusion from appropriate reproductive health care and sexual health screening, forced contraception and/or limited contraceptive choices, a focus on menstrual suppression, poorly managed pregnancy and birth, selective or coerced abortion and the denial of rights to parenting.<sup>22</sup> These practices are framed within traditional social attitudes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.<sup>23</sup>

# OVERVIEW

10. This Submission from Women With Disabilities Australia (WWDA) to the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* supplements many of the submissions, reports, articles, and letters previously provided by WWDA to successive Australian Governments on this issue over the last twelve years. This Submission does not intend to replicate all that work,<sup>24</sup> but instead seeks to highlight key issues for consideration, in recognition that women and girls with disabilities have the right to experience full and effective enjoyment of their human rights on an equal basis as others. Indeed, the right to be fully human.<sup>25</sup>
11. This Submission examines the background to the issue of forced and coerced sterilisation of women and girls with disabilities in Australia and highlights the status of the issue in Australia today. It examines the rationale used to justify the forced sterilisation of disabled women and girls, including themes such as eugenics/genetics; for the good of the State, community or family; incapacity for parenthood; incapacity to develop and evolve; prevention of sexual abuse; and discourses around “best interest”. In doing so, this Submission analyses Australian Court and Tribunal applications and authorisations for sterilisation of disabled women and girls, and demonstrates that in reality, applications and authorisations for sterilisation have very little to do with the ‘best interests’ of the individual concerned, and more to do with the interests of others. This Submission demonstrates that the Australian Government’s current justification of the “best interest approach” in the sterilisation of disabled women and girls, has in effect, been used to perpetuate discriminatory attitudes against women and girls with disabilities, and has only served to facilitate the practice of forced sterilisation.
12. The impact of forced sterilisation on women and girls with disabilities is also highlighted in this Submission, and reaffirms that forced and coerced sterilisation has long-lasting physical, psychological and social effects and causes severe mental pain and suffering, extreme psychological trauma, including depression and grief. It also demonstrates that for women with disabilities, the issue of forced sterilisation encompasses much broader issues of reproductive health, including for example: support for choices and services in menstrual management, contraception, abortion, sexual health management and screening, pregnancy, birth, parenting, menopause, sexuality, violence and sexual assault prevention and more.
13. This Submission looks in detail at forced sterilisation as a violation of human rights and provides an analysis of how the practice contravenes every international human rights treaty to which Australia is a party. It examines the human rights treaty monitoring bodies responses to the practice of forced sterilisation around the world and clearly demonstrates that Australia’s apathy and indifference to the issue sees it lagging behind the rest of the developed world, at the expense of the human rights of disabled women and girls.

# OVERVIEW

14. The Submission provides examples of several recent legal cases to highlight that the issue of forced and coerced sterilisation of women and girls is increasingly being recognised in Courts around the world, as a violation of women's fundamental human rights. Importantly, WWDA's Submission also examines redress and transitional justice for women and girls with disabilities who have been sterilised in the absence of their fully informed and free consent. In doing so, the Submission looks at the necessary components of redress and transitional justice, including for example: measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.
15. Given the magnitude of the issue of forced sterilisation of women and girls with disabilities, in that it represents just one element of a much broader pattern of denial of human and reproductive rights of Australian disabled women and girls, it is outside the scope of this Submission to address in detail the wide-ranging and extensive raft of actions required to address the breadth and scope of issues involved. This Submission has, however, endeavoured to identify key recommendations for consideration, whilst acknowledging that much more intensive work is required. Critically, any work in this area, must be based on the understanding that women and girls with disabilities must be at the forefront of any and all consultative and decision-making processes.
16. Forced sterilisation of women and girls with disabilities, and the inadequacy of Australian Governments' responses to it, represent grave violations of multiple human rights. The Australian Government is obliged to exercise due diligence to: prevent the practice of forced and coerced sterilisation from taking place; investigate promptly, impartially and effectively all cases of forced sterilisation of women and girls with disabilities; remove any time limits for filing complaints; prosecute and punish the perpetrators, and, provide adequate redress to all victims of forced or coerced sterilisation. Meeting these obligations requires the Australian Government to take into account the marginalisation of disabled women and girls, whose rights are compromised due to deeply rooted power imbalances and structural inequalities, and to take all appropriate measures, including focused, gender-specific measures to ensure that disabled women and girls experience full and effective enjoyment of their human rights on an equal basis as others. Nothing less is acceptable.
17. Whilst WWDA welcomes the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia* as a long-overdue initiative and commends the Senate for recognising the imperative to address this long neglected yet urgent human rights issue, we re-iterate that there are absolutely no grounds or excuses which can be used to justify the torture of women and girls with disabilities by forced sterilisation.



# KEY RECOMMENDATIONS

# KEY RECOMMENDATIONS

Based on the information provided in this Submission, coupled with WWDA's extensive and dedicated work on this issue for more than twelve years, WWDA makes the following 18 Key Recommendations to the Australian Government through the *Senate Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*:

## RECOMMENDATION 1

As an immediate action, in keeping with the human rights treaties to which Australia is a party, and consistent with the recommendations to the Australian Government from the United Nations *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), the *Committee on the Rights of the Child* (CRC/C/15/Add.268; CRC/C/AUS/CO/4), the *Human Rights Council* (A/HRC/17/10), along with the *International Federation of Gynecology and Obstetrics (FIGO) Guidelines on Female Contraceptive Sterilization* (2011); recommendations of the *World Medical Association (WMA)* (2011) and the *International Federation of Health and Human Rights Organisations (IFHHRO)* (2011), and the February 2013 Recommendations of the *UN Special Rapporteur on Torture* (A/HRC/22/53) **enact national legislation prohibiting, except where there is a serious threat to life, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.** Such legislation must prohibit the removal of a child or adult with a disability from Australia with the intention of having a forced sterilisation procedure performed.

---

## RECOMMENDATION 2

In consultation with women with disabilities, and as a matter of urgency, establish and adequately resource a National Task Force<sup>26</sup> to develop a **Policy and Framework for Transitional Justice and Redress** to address the forced and coerced sterilisation of women and girls with disabilities in Australia. Such a policy and framework must be consistent with the *United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law* (A/RES/60/147), the *Convention on the Rights of Persons With Disabilities* (A/RES/61/106) and other relevant international standards and frameworks.<sup>27</sup> The following elements as articulated under the *Convention Against Torture [and Other Cruel, Inhuman or Degrading Treatment or Punishment]*, must be included: measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.

---



# KEY RECOMMENDATIONS

## RECOMMENDATION 3

In developing measures of **rehabilitation and recovery** for those affected by forced sterilisation practices and other violations of their reproductive rights and freedoms, women and girls with disabilities must be actively consulted to identify the full range of rehabilitation and recovery measures required, which may include for example:

- specialised counselling, psychological, and social programs, services and supports;
  - provision of legal services, supports and assistance for survivors;
  - specialised women's health, allied health and medical programs, services and supports;
  - specialised and targeted violence and sexual assault prevention services, programs and support;
  - specialised reproductive and sexual health education and training services and programs;
  - processes for memorialising and documenting the experiences, stories and histories of those affected.
- 

## RECOMMENDATION 4

Issue a **formal apology** that identifies the discriminatory actions, policies, culture and attitudes that result in forced and coerced sterilisation of people with disabilities and that acknowledges, on behalf of the nation, the harm done to those who have been forcibly sterilised and experienced other violations of their reproductive rights. The formal apology must be developed in consultation with those affected and their allies, and satisfy the five criteria for formal apologies as articulated by the Canadian Law Commission, which include:

- acknowledgment of the wrong done or naming the offence.
  - accepting responsibility for the wrong that was done.
  - the expression of sincere regret and profound remorse.
  - the assurance or promise that the wrong done will not recur.
  - reparation through concrete measures.
-



# KEY RECOMMENDATIONS

## RECOMMENDATION 5

Provide **financial reparation** to women and girls with disabilities who have been forcibly sterilised. In establishing a scheme for financial reparation, the Australian Government should examine similar models used in Canada, Sweden and the US, including the *North Carolina Justice for Sterilization Victims Foundation*, established in 2010.

---

## RECOMMENDATION 6

In consultation with people with disabilities and their allies, and consistent with the *Convention on the Rights of Persons With Disabilities*, act to undertake the following **legislative reforms**:

- enact national legislation that replaces regimes of substitute decision making for people with disabilities with supported decision-making;
  - repeal any laws, policies and practices which permit guardianship and trusteeship for adults (and replace regimes of substitute decision-making with supported decision making);
  - ensure that the requirement for prior, full and informed consent in all interventions and treatments concerning people with disabilities is enshrined in relevant legal frameworks at national and state/territory levels;
  - ensure that criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent is clarified in the law, and that no distinction between persons with or without disabilities is made; and,
  - ensure that any law or policy which restricts in any way, a disabled woman's [and girls] right to full enjoyment of her sexual and reproductive health rights and freedoms, is amended as a matter of urgency.<sup>28</sup>
-

# KEY RECOMMENDATIONS

## RECOMMENDATION 7

In keeping with recommendations from the Committee on the Elimination of Discrimination Against Women (CEDAW/C/AUS/CO/7), act to **adopt urgent measures** to ensure that women with disabilities are better represented in decision-making and leadership positions, and that structures, mechanisms and initiatives are established to enable and foster their participation and engagement. Inherent in this is the need for the Australian Government to undertake an immediate and urgent review of the level and adequacy of the annual funding provided by the Australian Government to Women With Disabilities Australia (WWDA) (\$163,000) including its staffing levels (1 EFT).

---

## RECOMMENDATION 8

Act immediately to commission and adequately resource a **National Public Inquiry** into the removal and/or threat of removal of babies and children from parents with disabilities. Such an Inquiry must investigate reasons why in Australia today, a parent with a disability is up to ten times more likely than other parents to have a child removed from their care.<sup>29</sup> The Inquiry must also address the over-representation of parents with intellectual disabilities in care and protection proceedings.

---

## RECOMMENDATION 9

Act immediately on the urgent recommendation of the *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), to **address the violence, abuse, neglect and exploitation** experienced by women and girls with disabilities living in institutions or supported accommodation. Inherent in this is the need to develop and resource targeted, gendered initiatives to build capacity of individuals and organisations to prevent violence against people with disabilities and to ensure appropriate responses when it does occur.

---

# KEY RECOMMENDATIONS

## RECOMMENDATION 10

As a matter of urgency, and consistent with recommendations from other key Australian disabled people's organisations, establish and adequately resource an independent, statutory, **national protection mechanism** for 'vulnerable' and/or 'targeted' adults, where the requirement for mandatory reporting is legislated.

---

## RECOMMENDATION 11

Commission and fund a three year **national research study** on women and girls with disabilities' right to reproductive freedom which:

- investigates models of best practice in the delivery of sexual and reproductive health programs and services for women and girls with disabilities, including on all matters relating to parenthood and relationships;
  - addresses the effects, including long-term effects, of forced and coerced sterilisation for all women and girls with disabilities, including those with psychiatric, cognitive, sensory and physical disabilities;
  - investigates the practice of menstrual suppression of girls and women with disabilities, including those in group homes and other forms of institutional care. Research into menstrual suppression practices must include:
  - investigation into the non-consensual and coerced administration of Depo-Provera and other injectable contraceptives, the contraceptive pill, and other forms of contraception to women and girls with disabilities;
  - investigation into the use of contraception as a form of social control of girls and women with disabilities;
  - investigation into the long term physical, psychological, and social effects of menstrual suppression practices.
-

# KEY RECOMMENDATIONS

## RECOMMENDATION 12

In consultation with women with disabilities and their allies, **commission specific work** to assist women and girls with disabilities and their families and support persons to access appropriate reproductive health care. Work in this area would need to include:

- Researching and implementing the specific supports required by carers/support persons to better assist them in managing the menstruation and reproductive health needs of women and girls with intellectual and/or cognitive disabilities;
  - Investigating the feasibility of establishing a national scheme (similar to schemes such as the Continence Aids Payment Scheme), which provides funding for all women and girls with disabilities and their families and support persons/carers to access appropriate reproductive health care;
  - Developing national sexual health protocols for women and girls with disabilities that incorporate options for menstrual management and contraception.
- 

## RECOMMENDATION 13

Establish, and recurrently fund a **National Resource Centre for Parents with Disabilities**, focusing on pregnancy and birthing, adoption, custody, assisted reproduction, adaptive baby-care equipment, as well as general parenting issues. In establishing such a Resource Centre, the Australian Government should examine similar Centres available in other countries, such as the US organisation 'Through the Looking Glass'.<sup>30</sup>

---

## RECOMMENDATION 14

Recognise, **support and strengthen** the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disabilities, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of a peak NGO for women with disabilities in each State and Territory.

---

# KEY RECOMMENDATIONS

## RECOMMENDATION 15

Ensure that information on women and girls with disabilities is provided in all human rights treaties **Periodic Reports** as a matter of course. This would include information on the situation of women with disabilities under each right, including their current de-facto and de jure situation, measures taken to enhance their status, progress made and difficulties and obstacles encountered. Inherent in this is the need to ensure disaggregated data is included in information provided under each right.

---

## RECOMMENDATION 16

Act to separate disability policy and disability support from family carer policy and support in order to **increase the autonomy** of women and girls with disabilities and challenge the stereotype of women and girls with disabilities as burdens of care.

---

## RECOMMENDATION 17

Through the National Registration and Accreditation Scheme for the Health Professions (NRAS),<sup>31</sup> act to ensure that **accreditation of the training of health professionals** covered under the *Health Practitioner Regulation National Law Act 2009*, is contingent on disability, gender and human rights specific curriculum components.

---

## RECOMMENDATION 18

Develop specific measures to ensure a **gender perspective** is incorporated into any national, state/territory initiatives undertaken as part of the domestic implementation of Article 8 [Awareness Raising] of the CRPD.

---



# TERMINOLOGY



# TERMINOLOGY

18. 'Sterilisation' refers to the performance of a medical procedure which permanently removes an individual's ability to reproduce, and/or the administration of medication to suppress menstruation. '*Forced/involuntary sterilisation*' refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to life. *Coerced sterilisation* occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent.<sup>32</sup>
19. In considering issues of sterilisation (whether referred to as non-therapeutic, involuntary, coerced) - it is important to be clear that any sterilisation carried out without the free and informed consent of the individual concerned, is a forced sterilisation.<sup>33</sup> This includes instances in which sterilisation has been authorised by a third party, such as a parent, legal guardian, court, tribunal, or judge, without the individual's consent.<sup>34</sup>
20. The practices that law makers and health care providers call 'unlawful,' 'unauthorised,' 'non-consensual,' 'involuntary,' or 'non-therapeutic' sanitises the picture of what really happens to disabled women and girls in their reproductive choices. For many, the experience is about being denied access to suitable services, forced against their will, coerced, intimidated, pressurised, deceived, compelled, raped and even unknowingly deprived of their human rights to bodily integrity and control over their reproductive health. In the case of sterilisation, the fact that a procedure may be deemed 'authorised' or 'lawful' does not in any way obviate the reality that a woman with a disability, often a very young woman or girl, undergoes a medical procedure to remove non-diseased parts of her body which are essential to her ongoing health and well-being.<sup>35</sup>

# TERMINOLOGY

21. Whilst there may be instances where disabled men and boys are subject to sterilisation procedures, sterilisation disproportionately affects women and girls and is clearly a gendered issue. Women and girls with disabilities are at particular risk of forced sterilisations performed under the auspices of legitimate medical care or the consent of others in their name.<sup>36</sup> The majority of cases that have come to the attention of relevant authorities in Australia (including Courts and Guardianship Tribunals) have involved the sterilisation of girls with intellectual disabilities.<sup>37</sup> Similarly, there have been no instances in Australia where authorisations to sterilise have been sought for children without disabilities in the absence of a threat to life or health.<sup>38</sup> In this context, this Submission focuses on women and girls with disabilities, whilst acknowledging that disabled men and boys who may be subject to forced or coerced sterilisation are entitled to the same protection against violations of their human rights as disabled women and girls. As recently highlighted by the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health:

*Women are generally more likely to experience infringements of their right to sexual and reproductive health given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Persistent stereotyping of women's roles within society and the family establish and fuel societal norms.*<sup>39</sup>

22. In discussing sterilisation of people with disabilities, it must also be understood that adult women with disabilities and men with disabilities have the same rights as their non-disabled counterparts to choose sterilisation as a means of contraception. In this context, safeguards to prevent forced sterilisation should not infringe the rights of disabled women and men to choose sterilisation voluntarily and be provided with all necessary supports to ensure that they can make and communicate such a choice based on their free and informed consent.

*"Women are generally more likely to experience infringements of their right to sexual and reproductive health given the physiology of human reproduction and the gendered social, legal and economic context in which sexuality, fertility, pregnancy and parenthood occur. Persistent stereotyping of women's roles within society and the family establish and fuel societal norms."*<sup>39</sup>



# BACKGROUND AND STATUS

# BACKGROUND AND STATUS

## BACKGROUND AND STATUS OF THE ISSUE IN AUSTRALIA

23. There is a historical precedent in several countries including for example the USA (until the 1950s), in Canada and Sweden (until the 1970s), and Japan (until 1996) indicating that torture of women and girls with disabilities by sterilisation occurred on a collective scale – that is, mass forced sterilisation. This policy was rationalised by a pseudo-scientific theory called eugenics – the aim being the eradication of a wide range of social problems by preventing those with ‘physical, mental or social problems’ from reproducing.<sup>40</sup>
24. Although eugenic policies have now been erased from legal statutes in most countries, vestiges still remain within some areas of the legal and medical establishments and within the attitudes of some sectors of the community:

*“Disabled people should not have babies.”<sup>41</sup>*

*“We neuter our dogs and cats for the perfectly ethical reasons such as their health, to lessen the natural biological impact it causes to their bodies and to ensure that they don’t breed unnecessarily..... If she [re Angela] were a cat, dog, horse, hamster we would do what we could to alleviate her burdens and to make sure she enjoyed the best quality of life she can have.”<sup>42</sup>*

*“She [re Angela] doesn’t have the skills necessary to raise a child herself (who will most likely be disabled too), so what use is a reproductive system anyway. Our health system is under enough pressure with the aging population without the addition to any more disabled people.”<sup>43</sup>*

*“Disabled children cost the council too much money and should be put down.”<sup>44</sup>*

*“We neuter our dogs and cats for the perfectly ethical reasons such as their health, to lessen the natural biological impact it causes to their bodies and to ensure that they don’t breed unnecessarily..... If she [re Angela] were a cat, dog, horse, hamster we would do what we could to alleviate her burdens and to make sure she enjoyed the best quality of life she can have.”<sup>42</sup>*

# BACKGROUND AND STATUS

25. In Australia the issue of sterilisation of disabled women and girls has been the subject of debate since the early 1980s when it became clear that many women with disabilities had been and were being sterilised without their consent and in many cases without their knowledge. It was clear this was happening with the informal consent of family, carers or doctors and without public scrutiny or accountability.<sup>45</sup> This was in keeping with the legacy of the coercive and government sanctioned mass sterilisation of women with disabilities in pre-war Australia.<sup>46</sup>
26. In 1992, in a case now known as *Marion's Case*,<sup>47</sup> an application was made to the High Court of Australia on appeal from the Family Court in relation to a teenage girl with an intellectual disability. The application was for a 'non-therapeutic'<sup>48</sup> surgical sterilisation in order to manage the young girl's menstruation and prevent pregnancy. The High Court found that fundamental questions of human rights such as the right to reproduce should be decided by the courts rather than by parents, carers or medical practitioners.<sup>49</sup> While this decision lent support to the rights of people with disabilities and has since assumed symbolic importance, subsequent judicial decisions and social practices have failed to give full effect to the promise of *Marion's Case*.<sup>50</sup> In reality considerations about forced sterilisation in Australia have remained effectively bogged down in an ongoing legalistic debate about who can authorise sterilisation, for whom, under what circumstances and within which jurisdiction.<sup>51</sup> The main concern of public policy in the area has focused on piecemeal development of mechanisms, protocols and guidelines in an attempt to '*minimise the risk of unauthorised sterilisations occurring*'.<sup>52</sup> Additionally, the legal question essentially addressed in the debates around forced sterilisation of women and girls with disabilities has been constructed as a decision about whether to sanction a 'medical procedure'.<sup>53</sup> This has resulted in the narrow conception of forced sterilisation as a legal and medical matter when it is clearly an issue of fundamental human rights.
27. In 2003, Chief Justice Alastair Nicholson (Chief Justice of the Family Court of Australia from 1988-2004) reflected on the apathy of successive Australian Governments in addressing the issue of sterilisation of disabled women and girls:

*"I have no real knowledge of why successive governments of both federal and state haven't taken a greater degree of interest in this area. It does concern me that the issue hasn't been taken up in any real sense. I know the Federal Government has made some attempts to draw attention to it through the Attorney General's department from time to time but that seems to be about as far as it's gone."*<sup>54</sup>



# BACKGROUND AND STATUS

28. In August 2003, Australian Governments, through the [then] *Standing Committee of Attorneys-General* (SCAG)<sup>55</sup> agreed that a nationally consistent approach to the authorisation procedures required for the lawful sterilisation of minors was appropriate. From 2003-2007, despite strong opposition from disability and human rights advocates, the SCAG pushed ahead with a proposal to develop legislation aimed to regulate authorisation of sterilisation of minors with a 'decision-making disability' rather than prohibit this form of violence.<sup>56</sup> In November 2006, the SCAG released for consultation with selected stakeholders, a draft Bill (*Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*).<sup>57</sup> The Bill set out the procedures that jurisdictions could adopt in authorising the sterilisation of children who have an intellectual disability.<sup>58</sup>
29. The SCAG disbanded its work on the Draft Bill in 2008, declaring that '*there would be limited benefit in developing model legislation*'<sup>59</sup> and instead, its Ministers agreed to '*review current arrangements to ensure that all tribunals or bodies with the power to make orders concerning the sterilisation of minors with an intellectual disability are required to be satisfied that all appropriate alternatives to sterilisation have been fully explored and/or tried before such an order is made*'.<sup>60</sup> There is no evidence to date that these reviews were conducted, and in fact, in 2009, one State Government Attorney-General advised WWDA in writing that no such review had been undertaken in that particular State and nor was there any intention to undertake such a review.<sup>61</sup>
30. In 2009, WWDA formally recommended to the Australian Government/s that the issue of sterilisation of girls and women with disabilities remain as a standing item on the SCAG agenda until such time that national legislation had been developed which prohibited forced sterilisation. Despite the fact that the Australian Government had conceded that: a) girls with disabilities continue to be sterilised in Australia,<sup>62</sup> and b) '*unrecorded and unauthorised non-therapeutic sterilisations of young women with intellectual disabilities [are] being undertaken in Australia*',<sup>63</sup> WWDA's recommendation was rejected, with the [then] Federal Attorney-General, Hon Robert McClelland advising WWDA that:

*'While appreciating your organisation's long advocacy on this issue.....I do not propose at this time to develop Commonwealth legislation or to pursue the issue further through SCAG.'*<sup>64</sup>

31. In 2009 the Australian Government formally asserted to the United Nations that:

*'a comprehensive review ... indicated that sterilisations of children with an intellectual disability had declined since the 1997 report <sup>65</sup> - to very low numbers. Evidence also indicated that alternatives to surgical procedures to manage the menstruation and contraceptive needs of women are increasingly available and seem to be successful in the most part. Further, while it was not possible to be definitive due to limitations in the available information, the review concluded that existing processes to authorise sterilisation procedures appeared to be working adequately due to improvements in treatment options and wider community awareness.'*<sup>66</sup>



# BACKGROUND AND STATUS

32. There was however, no evidence to support that a 'comprehensive review' (including '*evidence and information gathered relating to the issue*')<sup>67</sup> had been undertaken. No report was ever made available to stakeholders who participated in the consultations on the SCAG 2006 draft legislation, and repeated requests by WWDA to the Australian Government for the report of the 'comprehensive review' were ignored.<sup>68</sup>
33. Forced sterilisations continue to occur in Australia,<sup>69</sup> despite the Australian Government's assertion that only 'very low numbers' of children with an intellectual disability are sterilised. A documentary by ABC TV program '*Four Corners*' in 2003 into sterilisation of people with disabilities, reported on a number of girls and women with disabilities who had been illegally sterilised. Four Corners also '*made contact with families who have had their daughters sterilised illegally.....they would not come on camera for fear of prosecution*'.<sup>70</sup> The Program identified that '*some parents, frustrated by the system, are now seeking out illegal sterilisations or finding ways to get around the system*'. The program interviewed a couple who had their 15 year old disabled daughter '*secretly sterilised in hospital*'. The doctor booked the young girl into the hospital in the mother's name. The mother explained:

*'no one questioned me. No one, none of the nurses, no one. We were in a private room, we were on our own, and I stayed with her and then I brought her home and nursed her and she was fine..... It's something we have to do behind closed doors because people don't understand.'*<sup>71</sup>

34. In another case, a couple had their 15 year old disabled daughter sterilised in the United States. The parents wanted their daughter sterilised for menstrual management purposes and also to prevent a possible pregnancy in the future. The mother was of the view that, for her daughter to be sterilised in Australia would have been 'virtually impossible' and 'we'd have to break the law'. She explained:

*'I've got many friends that have been down the line and been knocked back, some friends going through the process at the moment, some friends that it will come up in the next couple of years. The motivation for a parent to get an illegal sterilisation would be they're doing the best for their child. Health and hygiene would be the utmost. And they would be desperate. And, yeah, I'd go down that track if we were not able to get a hysterectomy for Laura in the States.'*<sup>72</sup>

# BACKGROUND AND STATUS

35. Although forced sterilisation breaches every international human rights treaty to which Australia is a party, and is a practice that constitutes torture, successive Australian Governments have consistently taken the view that there are instances in which forced sterilisation can and should be authorised, as evidenced for example, in the current Australian Government's 2009 Report to the United Nations under the *Convention on the Rights of the Child* (CRC):

*A blanket prohibition on the sterilisation of children could lead to negative consequences for some individuals. Applications for sterilisation are made in a variety of circumstances. Sometimes sterilisation is necessary to prevent serious damage to a child's health, for example, in a case of severe menstrual bleeding where hormonal or other treatments are contraindicated. The child may not be sexually active and contraception may not be an issue, but the concern is the impact on the child's quality of life if they are prevented from participating to an ordinary extent in school and social life.<sup>73</sup>*

*'I've got many friends that have been down the line and been knocked back, some friends going through the process at the moment, some friends that it will come up in the next couple of years. The motivation for a parent to get an illegal sterilisation would be they're doing the best for their child. Health and hygiene would be the utmost. And they would be desperate. And, yeah, I'd go down that track if we were not able to get a hysterectomy for Laura in the States.'<sup>72</sup>*

# BACKGROUND AND STATUS

36. In June 2011, WWDA lodged a formal complaint with four of the United Nations Special Rapporteurs, requesting urgent intervention from each of their offices simultaneously.<sup>74</sup> The Special Rapporteurs<sup>75</sup> wrote to the Australian Government on 18 July 2011 seeking a formal response in relation to the alleged ongoing practice of forced sterilisation of girls and women with disabilities in Australia (see Appendix 2). The Government's response, provided to the UN on 16 December 2011 (see Appendix 3), outlined the different laws governing sterilisation in Australia; and stated that *'sterilisations are authorised only where they are the last resort, as less invasive options have failed or are inappropriate, and where they are in a person's best interests'*. The response demonstrates that the Australian Government does not currently have a coherent national approach to sterilisation of women and girls with disabilities and indicates that the Australian Government remains of the view that there are instances in which forced sterilisation of disabled girls and women, can and should be authorised.
37. Since 2005, United Nations treaty monitoring bodies have consistently and formally recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.<sup>76</sup>
38. In June 2012, the Committee on the Rights of the Child (CRC), in its *Concluding Observations*<sup>77</sup> to the Fourth periodic report of Australia,<sup>78</sup> expressed its serious concern that the absence of legislation prohibiting non-therapeutic sterilisation of girls and women with disabilities *"is discriminatory and in contravention of article 23(c) of the Convention on the Rights of Persons with Disabilities....."*. The Committee urged the State party to: *'Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities.'* Furthermore, the Committee clearly identified non-therapeutic sterilisation as a form of violence against girls and women, and recommended that the Australian Government *'develop and enforce strict guidelines to prevent the sterilisation of women and girls who are affected by disabilities and are unable to consent.'*
39. In January 2011, in follow-up to Australia's *Universal Periodic Review*,<sup>79</sup> the UN Human Rights Council endorsed a recommendation specifically addressing the issue of sterilisation of girls and women with disabilities. It specified that the Australian Government should enact national legislation prohibiting the use of non-therapeutic sterilisation of children, regardless of whether they have a disability, and of adults with disabilities without their informed and free consent.<sup>80</sup> The Australian Government's formal response to this recommendation illustrates its blatant disregard of the human rights of women and girls with disabilities:

*'The Australian Government will work with states and territories to clarify and improve laws and practices governing the sterilisation of women and girls with disability.'*<sup>81</sup>

# BACKGROUND AND STATUS

40. In July 2010, at its 46<sup>th</sup> session, the UN Committee on the Elimination of Discrimination against Women (CEDAW) expressed concern in its *Concluding Observations on Australia* at the ongoing practice of non-therapeutic sterilisations of women and girls with disabilities and recommended that the Australian Government ‘enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.’<sup>82</sup> In September 2012, the Australian Government submitted its Interim Report to the CEDAW Committee,<sup>83</sup> to address how it was responding to the recommendations from the 2010 *CEDAW Concluding Observations on Australia*,<sup>84</sup> specifically on violence against women, and Aboriginal and Torres Strait Islander women. Despite the fact that forced sterilisation of women and girls with disabilities constitutes violence against women,<sup>85</sup> the Australian Government’s 42 page response completely ignores the CEDAW recommendation on sterilisation of women and girls with disabilities.
41. In 2005, the Committee on the Rights of the Child in considering Australia’s combined second and third periodic reports<sup>86</sup> under Article 44 of the *Convention on the Rights of the Child* (CRC), recommended that ‘the State party.....prohibit the sterilization of children, with or without disabilities....’<sup>87</sup> and in 2007 clearly articulated its position on sterilisation of girls with disabilities, clarifying that States parties to the CRC are expected to prohibit by law the forced sterilisation of children with disabilities.<sup>88</sup>
42. To date, the Australian Government has failed to comply with any of these recommendations.
43. Australia is due to report to the United Nations Human Rights Committee on Australia’s compliance with the *International Covenant on Civil and Political Rights* (ICCPR). It is required to submit its response to the List of Issues Prior to Reporting (LOIPR),<sup>89</sup> (adopted by the Human Rights Committee at its 106<sup>th</sup> session in late 2012) by 1 April 2013 and is scheduled to appear for review by the Human Rights Committee in 2014. Under the heading of ‘Violence Against Women’, the LOIPR for Australia contains a question on sterilisation, to which the Australian Government is expected to respond.<sup>90</sup> Specifically, it states:

*Please provide information on whether sterilization of women and girls, including those with disabilities, without their informed and free consent, continues to be practiced, and on steps taken to adopt legislation prohibiting such sterilisations.*

# BACKGROUND AND STATUS

44. Australia is also due to report to the United Nations Committee on the Rights of Persons with Disabilities (CRPD). In April 2013, the CRPD Committee will meet at its 9<sup>th</sup> session<sup>91</sup> to develop the List of Issues Prior to Reporting (LOIPR) for Australia in relation to its compliance with and implementation of the *Convention on the Rights of Persons with Disabilities*. Australia's NGO Shadow Report to the CRPD<sup>92</sup> Committee will be considered in the development of the LOIPR for Australia along with information provided by WWDA. It is anticipated that the CRPD LOIPR for Australia will include a specific question on the sterilisation of girls and women with disabilities.
45. International and national *NGO/Civil Society Shadow Reports*<sup>93</sup> submitted to the CRPD Committee for Australia's upcoming review under the CRPD, explicitly deal with the issue of forced and coerced sterilisation of women and girls with disabilities, and call on the Australian Government to prohibit the practice as well as develop specific legislation prohibiting medical treatment and interventions of people with disabilities without their free and informed consent.
46. In addition to the important analysis and condemnation of forced and coerced sterilisation of disabled women and girls by UN mechanisms, international medical bodies have now developed new protocols and calls for action to put an end to the practice of forced/involuntary sterilisation. In June 2011, the International Federation of Gynecology and Obstetrics (FIGO) released new *Guidelines on Female Contraceptive Sterilization*<sup>94</sup> shoring up informed consent protocols and clearly delineating the ethical obligations of health practitioners to ensure that women, and they alone, are giving their voluntary and informed consent to undergo a surgical sterilisation. The FIGO Guidelines (see Appendix 1) clearly state that: *'It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.'* Yet the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), a member of FIGO, has recently asserted that:

*no method of menstrual regulation or sterilisation is perfect, and a small number of disabled girls or women may still have their best interests served by hysterectomy or sterilisation.*<sup>95</sup>

# BACKGROUND AND STATUS

47. In September 2011, the *World Medical Association* (WMA) released a statement condemning the practice of forced and coerced sterilisation as a serious breach of medical ethics. WMA President, Dr. Wonchat Subhachaturas, called involuntary sterilisation “*a misuse of medical expertise, a breach of medical ethics, and a clear violation of human rights.*” On behalf of the WMA, he issued a call to “*all physicians and health workers to urge their governments to prohibit this unacceptable practice.*”<sup>96</sup>
48. In October 2012, the *International NGO Council on Violence against Children*,<sup>97</sup> classified ‘sterilisation of children with disabilities’ as a harmful practice based on tradition, culture, religion or superstition.<sup>98</sup> It has urged States to prohibit the practice by law as a matter of urgency.
49. In 2012, the World Health Organisation (WHO) commenced work on the development of a *WHO Statement on Involuntary Sterilization*,<sup>99</sup> which addresses involuntary sterilisation of people with disabilities. The Statement will highlight the problem of involuntary sterilisation and will reaffirm the commitment of WHO to uphold human rights in the area of sexual and reproductive health. It will enable WHO to support Member States to ensure that law, policy and practice are in line with human rights standards and ethical principles and contribute to implementing best practices among policy-makers, professionals, and civil society. The Statement will be launched in the second quarter of 2013.

*‘no method of menstrual regulation or sterilisation is perfect, and a small number of disabled girls or women may still have their best interests served by hysterectomy or sterilisation.’<sup>95</sup>*



# BACKGROUND AND STATUS

50. The *Global Stop Torture in Health Care Campaign*<sup>100</sup> has identified forced sterilisation as one of its three priority issues for international action.<sup>101</sup> In doing so, it states:

*'Although sterilization may be carried out by individual health providers, it is ultimately the responsibility of governments to prevent such abuses from taking place. Governments must protect individuals from forced sterilization and guarantee all people's right to the information and services they need to exercise full reproductive choice and autonomy.'*

*'Although sterilization may be carried out by individual health providers, it is ultimately the responsibility of governments to prevent such abuses from taking place. Governments must protect individuals from forced sterilization and guarantee all people's right to the information and services they need to exercise full reproductive choice and autonomy.'*



# RATIONALE

# RATIONALE

## RATIONALE USED TO JUSTIFY FORCED STERILISATION IN AUSTRALIA

51. Forced sterilisation is performed on young girls and women with disabilities for various purposes, including eugenics-based practices of population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse).<sup>102</sup> In Australia, the reasons used to justify forced sterilisations generally fall into four broad categories, all couched as being in the "best interests" of women and girls with disabilities: a) the genetic/eugenic argument; b) for the good of the state, community or family; c) incapacity for parenthood; and d) prevention of sexual abuse.

## THE GENETIC/EUGENIC ARGUMENT

52. This line of argument is based on the fear that disabled women will re/produce children with genetic 'defects'. For example, in 2004, the Family Court of Australia authorised the sterilisation of a 12 year old intellectually disabled girl with Tuberous sclerosis, a genetic disorder with a 50% inheritance risk factor. Although one out of two people born with tuberous sclerosis will lead 'normal' lives with no apparent intellectual dysfunction, the Court accepted evidence from a medical specialist that sterilisation was in the best interests of the young girl because:

*"the result will be complete absence of menstruation and this will undoubtedly be of benefit to H who already appears to have substantial difficulties with cleanliness..... As a by-product of an absence of her uterus H will never become pregnant. Given the genetic nature of her disorder and the 50% inheritance risk thereof, this would in my view be of great benefit to H."*<sup>103</sup>

*"the result will be complete absence of menstruation and this will undoubtedly be of benefit to H who already appears to have substantial difficulties with cleanliness..... As a by-product of an absence of her uterus H will never become pregnant. Given the genetic nature of her disorder and the 50% inheritance risk thereof, this would in my view be of great benefit to H."*<sup>103</sup>

# RATIONALE

53. This reasoning is clearly grounded in eugenic ideology and in the broad views that society holds of disability as a burden, a personal tragedy or a medical problem, as evidenced by these recent examples of public responses to newspaper articles regarding sterilisation of disabled women and girls in Australia:

*".....Personally I think people with any medium level to high level disability should be completely sterilised to keep the gene pool clean." <sup>104</sup>*

*"The severity of disability needs to be considered, as well as the genetic likelihood of the disability being passed on." <sup>105</sup>*

*"The government shouldn't have to support unwanted babies let alone disabled children having disabled children." <sup>106</sup>*

*"Considering that evolution is merely random mutations of DNA between generations with the result being that some will be stronger and more prone to survival while others will, unfortunately, be weaker and thus suffer a higher mortality rate it would appear irresponsible to allow a 'profoundly disabled' person to have offspring anyway." <sup>107</sup>*

*Someone I know worked in a mental institution and she told me that the disabled often have very high sexual urges and they often do the deed with each other and then fall pregnant. It apparently results in lots of abortions so sterilisation is certainly a good option.<sup>108</sup>*

*"If you have ever looked after those with a mental disability you would never let them have children - they will end up in care adding to the problem." <sup>109</sup>*

*"Sterilisation is a common sense approach to anyone not capable of independently looking after a child. Lets forget about the rights of mentally incapacitated adults and lets think about the rights of children. The rights to be born with as close to 100% genetic ability to be "normal". The rights to have a "normal" parent(s). The right to be raised in a "normal" manner and to lead an independent and meaningful life that advantages society. There are way, way too many people on this earth already, to allow those that cannot independently raise children, to breed, is ludicrous."<sup>110</sup>*

*"The sterilization is a very human solution for all mentally and physically disabled people in their early age. This would be an answer to prevent many disabled person from ongoing problems in their whole life. If I would asking [sic] to vote what to do with them, I wouldn't hesitate to recommend the sterilization." <sup>111</sup>*

# RATIONALE

54. The residue of this type of thinking continues to have the potential for profound and alarming consequences for girls and women with disabilities.<sup>112</sup> As recently highlighted by Ms Rashida Mijoo, the UN Special Rapporteur on Violence against Women, its Causes and Consequences:

*Although society's fear that women with disabilities will produce so-called "defective" children is for the most part groundless, such erroneous concerns have resulted in discrimination against women with disabilities from having children.<sup>113</sup>*

55. There is clear evidence to indicate that the causes of impairment are overwhelmingly social and environmental (including for example: war, poverty, environmental degradation, neglect in healthcare, poor workforce conditions, gender-based violence and harmful traditional practices)<sup>114</sup> and only a small number are related to genetic causes.
56. Sterilisation is not 'a treatment of choice' for non-disabled women and girls with genetic disorders.

## FOR THE GOOD OF THE STATE, COMMUNITY OR FAMILY

57. Arguments here centre on the 'burden' that disabled women and girls and their potentially disabled children place on the resources and services funded by the state and provided through the community. A related and very commonly used argument, is the added 'burden of care' that menstrual and contraceptive management places on families and carers.
58. In a recent case, the Family Court of Australia authorised the sterilisation of an 11 year old girl with Rett Syndrome. The application was made by the young girl's mother to prevent menstruation. No independent children's lawyer was appointed to advocate for the girl, as the judge determined it would be of 'no benefit'. In accepting "without hesitation" the evidence of Dr T, an Obstetrician and Gynaecologist, the judge said:

*"Undoubtedly and certainly of significant relevance is that there are hygiene issues which must fall to the responsibility of her mother because Angela cannot provide for herself.... the operation would certainly be a social improvement for Angela's mother which in itself must improve the quality of Angela's life." <sup>115</sup>*

# RATIONALE

59. The 'burden' of parents having to deal with menstrual management of their disabled daughters is often used as a valid justification when Australian Courts authorise the sterilisation of disabled females - even before the onset of puberty.<sup>116</sup> For example, in authorising the sterilisation of a 12 year old girl in 2004, the Court accepted medical 'evidence' that caring for her was an "onerous responsibility" on her parents and that sterilisation would make the task of caring for her "somewhat less onerous", including that it would "make it easier for her carers if they had one less medication to administer."<sup>117</sup>
60. In the case of *Re Katie*,<sup>118</sup> the Court authorised the 15 year olds sterilisation at the onset of her menstruation, on the grounds that there would be 'appreciable easing of the burden' on the parents as primary carers:

*"It will lessen the physical burdens for the mother, in particular by decreasing the number of changes necessary in toileting, and quite possibly lessening the physical reactions, such as stiffening in body tone, which make Katie more difficult to handle during menstruation. It would lessen, for the parents, the risks of infection.....Katie's emotional welfare is best served by her continuing to reside in the family and by the demands of her presence being lessened as much as possible, to maximise the ability of the family, in particular the mother, to cope with Katie's needs. Thus the interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care."*

61. In late 2011, the Queensland Civil and Administrative Tribunal (QCAT) authorised the sterilisation of 'HGL', a 'severely intellectually disabled' 18 year old girl whose menstrual periods had commenced at the age of 17, which according to her parents, caused her 'distress'. Although it was agreed that '*the current hormone treatment is managing HGL'S menstruation*', a hysterectomy was authorised because:

*'there are risks that the medication will over time fail to achieve this effect and....HGL's current impairments mean that she will not be a candidate for surgery indefinitely.'*<sup>119</sup>



# RATIONALE

62. In the case of *Re S*<sup>120</sup>, a 12 year old 'severely intellectually disabled girl' who lived in an institution and who had not yet begun to menstruate, the Family Court granted authorisation for her to be sterilised because, according to the specialist paediatric surgeon arranged to carry out the operation:

*'it would be wiser to avoid problems rather than to wait and see if S copes with menstruation.....surely there is no need for her to suffer the problems that may arise with periodic menstruation', which included 'the possibility that she would develop a phobia of blood'. The judge agreed this was a 'realistic and appropriate view' and that 'there is no point in the child going through the problems associated with menstruation if she is not ever to bear children'.*

63. In *Re M*,<sup>121</sup> the Family Court authorised the sterilisation of a 15 year old girl prior to the onset of menstruation upon the basis that such treatment was "necessary to prevent serious damage to the child's health." The rationale for this decision included that: the young girl's mother and sister experienced 'painful periods' and "there is a very real risk that the same will happen to M"; that the young girl "played with her motions and played with herself" and this 'behaviour', coupled with menstruation, "could cause infections". Additional reasons for the decision to sterilise M included that she was: "aggressive"; "strong-willed"; "stubborn"; had a "poor frustration tolerance", was "unco-operative," was "a loner" and had "few friends".

*'it would be wiser to avoid problems rather than to wait and see if S copes with menstruation.....surely there is no need for her to suffer the problems that may arise with periodic menstruation', which included 'the possibility that she would develop a phobia of blood'. The judge agreed this was a 'realistic and appropriate view' and that 'there is no point in the child going through the problems associated with menstruation if she is not ever to bear children'.*

# RATIONALE

64. In yet another case of a young disabled girl aged 15 years who had yet to commence menstruation, sterilisation was authorised by the Family Court in support of her mother's submission that menstruation *'might induce a higher incidence of fits; and the sight of unexplained blood will lead to confusion and fear, which could lead to an increased incidence of fitting'*. The Court also accepted the mother's concern, which was supported by 'medical experts', that:

*'menstruation will be yet another hazard and perhaps mitigate against (her) chances of being adopted should the mother die.'*<sup>122</sup>

65. 'Bad and unruly behaviour' associated with menstruation is another dimension in applications for, and authorisations of sterilisation of young disabled girls and women:

*"Dr Py. records that "staff" at the ward in which Sarah resides, have told him that she becomes a problem during her menstrual period as she has no concept of personal care, cleanliness or propriety."*<sup>123</sup>

*"Mrs M [residential care officer] said that S was the most difficult of the six children in the Villa for which she is responsible and that masturbation is a virtual constant activity of the child. It appears that if S is restrained from engaging in masturbation she reacts badly. Mrs M has difficulty in encouraging S to do basic tasks and described the child as being "among the worst" in that regard."*<sup>124</sup>

*"During the menstrual time, Katie grinds her teeth, throws tantrums, collapses her legs, she seems tired and this has caused her to miss part or whole school days..... She is extremely impatient at meal times.....During the menstrual and pre-menstrual period, because of the changes to her temperament, Katie is not taken horse-riding."*<sup>125</sup>

*"Dr Py. records that "staff" at the ward in which Sarah resides, have told him that she becomes a problem during her menstrual period as she has no concept of personal care, cleanliness or propriety."*<sup>123</sup>

# RATIONALE

66. In a 2011 application to the NSW Guardianship Tribunal, a specialist gynaecologist (Dr HJK) lodged an application to perform a sterilisation procedure on a 22 year old woman with Down Syndrome.<sup>126</sup> In the application form Dr HJK recorded the proposed treatment, but he did not provide any details of the treatment, its consequences or provide details of complications likely to be associated with the procedure. He did record that Miss XTV has Down's Syndrome and that *"Patient becomes distressed and difficult to manage during menstruation"*. The 'behaviour management problems during menstruation' identified by Miss XTV's mother in the application, and supported by the gynaecologist, included that Miss XTV became *'obsessive with possessions; exhibited anxiety at any change in circumstance and routine; regressed with self-help skills; and developed a phobia about barricades on upper floors of shopping centres'*. Although the application was dismissed in 2012, the Tribunal stated:

*We take this opportunity to note that should the alternate procedure of the insertion of a Mirena IUCD not be carried out, or carried out but not prove effective, and/or other causes of Miss XTV's behaviours be eliminated, the evidentiary onus required to be satisfied to give consent to endometrial ablation may be met. In those circumstances there is nothing to prevent a further application to the Tribunal for consent.*

67. In terms of the 'burden' on families of the care of girls and women with disabilities, lack of resources and appropriate education and support services, respite care, school and post-school options, see many families already struggling to manage the care of their girl or young woman with disabilities. Faced with the prospect of added personal care tasks in dealing with menstruation and in the limited availability or accessibility of specific reproductive health and training services (including those for menstrual management), families may well see sterilisation as the only option open to them.<sup>127</sup> The denial of a young woman's human rights through the performance of an irreversible medical intervention with long term physical and psychological health risks is wrongly seen as the most appropriate solution to the social problem of lack of services and support.<sup>128</sup>
68. Evidence suggests however that menstrual and contraceptive concerns, even for women and girls with high support needs can be successfully met with approaches usually taken with non-disabled women and girls.<sup>129</sup> Research has found that when parents and carers are given appropriate support and resources the issue of sterilisation loses potency.<sup>130</sup>

# RATIONALE

69. A diagnosis of intellectual disability does not by itself constitute a clinical reason for sterilisation. The onset of menstruation is the same in girls with and without intellectual disabilities, and girls with intellectual disabilities present with the same types of common menstrual problems as the rest of the young female population.<sup>131</sup> Arguments for elimination of menstruation in girls and young women with disabilities are primarily about social taboos.<sup>132</sup>
70. Sterilisation is not 'a treatment of choice' for non-disabled females who are approaching menstruation, who menstruate, or who experience menstrual problems. Like their non-disabled counterparts, women and girls with disabilities have the right to bodily integrity, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a natural way, and the right to be parents.<sup>133</sup>

## INCAPACITY FOR PARENTHOOD

71. Australia has a history of removing children from their natural parents based on the personal characteristic of the parents, such as indigenous background or marital status. In Australia today, a parent with a disability is up to ten times more likely than other parents to have a child removed from their care.<sup>134</sup> Courts and child protection authorities are removing children from their parents on the basis of the parent's disability rather than actual neglect or abuse. A parent's capacity to parent his or her child, even with full community support is not properly assessed:<sup>135</sup>

*"My son was removed from my care when he was born by the department of child safety. They hadn't assessed my abilities as a parent nor did they tell me they were going to take away my son before I gave birth. They didn't trust me and said that they wanted to prevent me from harming my baby, even when I had done nothing wrong. No support has ever been provided to help me be a parent of my son. We got an independent assessment done and it showed that even though I have a mild intellectual impairment, my behavioural functioning is normal. Even now, I only see him every Friday and he stays overnight once a fortnight."*<sup>136</sup>

72. Widely held societal attitudes that disabled women cannot be effective parents mean there is pressure to prevent pregnancy in disabled women, particularly women with intellectual disabilities. Women with disabilities are typically seen as child-like, asexual or over-sexed, dependent, incompetent, passive, and genderless<sup>137</sup> and therefore considered inadequate for the 'nurturing, reproductive roles considered appropriate for women'.<sup>138</sup> For women with intellectual disabilities, the label of intellectual disability per se is mistakenly taken for prima facie evidence of likely parental incapacity or risk of harm to the child.<sup>139</sup> This is also the case for women with psychosocial impairments.<sup>140</sup> Such incapacity is automatically deemed to be an irremediable deficiency in the parent such that it cannot be overcome.

# RATIONALE

73. Incapacity for parenthood is a common theme in applications for and Court authorisations of sterilisation of disabled females in Australia:

*'It is clearly established that S is unfit to, and ought not, bear a child.'*<sup>141</sup>

*'Katie could not possibly care for a child.'*<sup>142</sup>

*'A pregnancy would be disastrous.'*<sup>143</sup>

*'It is clear that H has at least moderate intellectual disability.....she would be unable to care for a child if she were to become pregnant.'*<sup>144</sup>

*'It is understood and accepted that the child would never marry or enter into any relationship in which she would bear children. She is quite unable to understand the processes of conception and birth and would be quite unable to bear a child. Pregnancy would be most likely to have a highly detrimental effect upon her and should she become pregnant, for her own sake, her pregnancy would be terminated.'*<sup>145</sup>

*'If she were to be the victim of sexual assault, and to become pregnant, this would be a very complicated situation, both ethically and medically. The hysterectomy would remove the chance of an unwanted pregnancy and further medical complications associated with a pregnancy.'*<sup>146</sup>

*'If she were to be the victim of sexual assault, and to become pregnant, this would be a very complicated situation, both ethically and medically. The hysterectomy would remove the chance of an unwanted pregnancy and further medical complications associated with a pregnancy.'*<sup>146</sup>

# RATIONALE

74. There is ample evidence that many women with disabilities successfully parent happy children within our communities.<sup>147</sup> There is no clear relationship between competence or intelligence and good parenting – in fact, more than six decades of research has demonstrated that intellectual disability per se is an unreliable predictor of parenting performance.<sup>148</sup>

## INCAPACITY TO DEVELOP AND EVOLVE

75. The determination of capacity is inextricably linked to the exercise of the right to autonomy and self-determination. To make a finding of incapacity results in the restriction of one of the most fundamental rights enshrined in law, the right to autonomy.<sup>149</sup> Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent is deemed sufficient to justify forced treatment.<sup>150</sup>
76. Incapacity is often used as a valid justification for Court authorisation of sterilisation of disabled women and girls. Incapacity in this context, is considered to be a fixed state, with no consideration given to the possibility of capacity evolving over time:

*"Those who are severely intellectually disabled remain so for the rest of their lives".<sup>151</sup>*

*"There is no prospect that she will ever show any improvement in her already severely retarded mental state." <sup>152</sup>*

*Katie would never be able to contribute to self-care during menstruation..... Katie is unable to understand re-production, contraception, pregnancy and birth and that inability is unlikely to change in the foreseeable future.<sup>153</sup>*

*Sarah is unable to understand reproduction, contraception and birth and that inability is permanent.....her condition will not improve.<sup>154</sup>*

*'HGL is unlikely, in the foreseeable future, to have capacity for decisions about sterilisation.' <sup>155</sup>*

*'There has been no alteration in H's capacity for eighteen months and it has been assessed that there will be no improvement in H in the future.'<sup>156</sup>*

77. Views such as these fail to acknowledge the fact that 'incapacity' can very often be a function of the environment and more often than not, a lack of support for the individual concerned.



# RATIONALE

78. In the case of *Re Katie*,<sup>157</sup> her lack of capacity was a key consideration in the Family Court's decision to approve her sterilisation at the age of 16. Katie was described as *'being able to finger feed, drink out of a cup and use a spoon with assistance'* yet determined as not having *'the cognitive capacity to understand what is required, nor does she have the motor skills necessary to take care of her needs, i.e. to change pads'*. However, it was also stated that it was *'likely that Katie will continue to make some slow progress in her development if able to participate fully in educational therapy programs. Failure to carry out the proposed surgery could significantly reduce her ability to participate in these programs.'* Paradoxically, Katie was sterilised because she had 'lack of capacity to develop' but also so that she might 'develop capacity'.
79. One of the key principles guiding the *Convention on the Rights of Persons with Disabilities* is 'respect for the evolving capacities of children with disabilities', a concept which should be seen as a positive and enabling process that supports the maturation, autonomy and self-expression of the child. Through this process, children progressively acquire knowledge, competencies and understanding. Research has shown that information, experience, environment, social and cultural expectations, and levels of support can dramatically impact the development of a child's capacities to form a view.<sup>158</sup>
80. It is evident however, that sterilisation is easier, quicker, and cheaper than providing the programs, services and supports to enable young disabled women and girls to 'progressively acquire knowledge, competencies and understanding' about their bodies, their sexuality, relationships, safety and their human rights:

*"the proposed operation would avoid the necessity of time-consuming and constantly repeated programmes to enable the child to acquire skills to manage her menstruation, thereby freeing her to learn important social skills which could only improve her quality of life and opportunities to lead a "normal" life."*<sup>159</sup>

*"the proposed operation would avoid the necessity of time-consuming and constantly repeated programmes to enable the child to acquire skills to manage her menstruation, thereby freeing her to learn important social skills which could only improve her quality of life and opportunities to lead a "normal" life."*<sup>159</sup>

# RATIONALE

81. The UN Special Rapporteur on Torture has recently re-iterated that the law should never distinguish between individuals on the basis of capacity or disability in order to permit sterilisation specifically of people [girls and women] with disabilities.<sup>160</sup> Yet in the 2009 case of *Re BAH*,<sup>161</sup> a 14 year old disabled girl whose mother sought to have her sterilised prior to the onset of menstruation, the NSW Guardianship Tribunal stated:

*Ms BAH's disability is clearly central to the Tribunal's deliberations in this matter. But for Ms BAH's intellectual disability, the Tribunal would not have given consideration to the proposed treatment.*

## PREVENTION OF SEXUAL ABUSE

82. Sterilisation has been said to protect disabled women and girls from sexual abuse and the consequences of abuse.<sup>162</sup> Indeed, 'vulnerability to sexual abuse' is a dominant theme in many of the applications seeking authorisation for sterilisation of disabled women and girls in Australia.<sup>163</sup> In this context, 'inappropriate behaviour', and 'good looks' are considered major determinants of sexual activity or abuse.<sup>164</sup>
83. For example, in the case of *Re Katie*,<sup>165</sup> her 'attractive looks' were considered to make her more 'vulnerable' to sexual abuse, and formed part of the Court's rationale for her to be sterilised at the aged of 16:

*"It is highly unlikely that Katie will ever have the capacity to understand and voluntarily enter into a sexual relationship..... It is however well documented that disabled children are particularly vulnerable to sexual abuse and Katie is quite an attractive girl."*

*"It is highly unlikely that Katie will ever have the capacity to understand and voluntarily enter into a sexual relationship..... It is however well documented that disabled children are particularly vulnerable to sexual abuse and Katie is quite an attractive girl."*

# RATIONALE

84. Similarly, in a case<sup>166</sup> where the Court authorised the sterilisation of a 14 year old girl prior to the onset of menstruation, the judge stated:

*"it is unlikely she will have any form of relationship involving sexual intercourse. She could, of course, be the victim of a sexual assault and with her normal physical development and attractive looks that cannot be discounted.*

85. In *JLS v JES*,<sup>167</sup> where authorisation for sterilisation was sought for a 14 year old girl who was described as 'extremely severely handicapped', prevention of sexual abuse was a key factor in seeking the application. According to the Judge, the young girl's mother 'expressed concern at the possibility of the child becoming pregnant through sexual abuse while out of the plaintiff's direct supervision, as would increasingly occur as she approaches adulthood. The mother expresses a moral opposition to the concept of abortion.....' A number of 'experts' supporting the application identified risk of sexual abuse as 'evidence' of why the sterilisation should be authorised:

*"I do agree, especially as she is an attractive girl, that she is at great risk of pregnancy and also of pelvic infection as she develops sexual maturity."* [Consultant Neurologist]

*"It would prevent a pregnancy, to the risk of which the child might become exposed in more social environments such as Respite Care, out of continual supervision by her mother. Having regard to her mental retardation she was incapable of communicating any symptoms relating to pregnancy. An epileptic episode during pregnancy would increase three or four times the risk of foetal abnormality."* [Consultant Obstetrician and Gynaecologist]

*'...it was unacceptable to have her exposed to the risk of becoming pregnant having regard to her mental retardation, epilepsy and condition generally.'* [Consultant Obstetrician and Gynaecologist]

# RATIONALE

86. In other cases, the young girls' 'behaviour' with men was a consideration in authorising their sterilisation prior to the onset of their menstruation:

*"Ever since Elizabeth was a very young child, she was prone to run to men. If her mother takes her out she will go to any man, including strangers. On many occasions in public when the mother has not been holding Elizabeth tightly, she has run over to a man who is a complete stranger and taken his arm. She shows no fear and would happily go off with any man. She has to be physically restrained from chasing after men in public and throwing her arms around them." 168*

*"S is likely to wander....[she] has a preference when singling out an adult for attention for men over women and particularly for men with beards.....S is generally solitary by choice.....[she] likes soft sticky textures and regularly engages in faecal smearing.....I have included the foregoing statements because they give something of an overall picture of the child. I would add that, if not common ground, it is clearly established that S is unfit to, and ought not, bear a child." 169*

*"...since the onset of sexual maturity she displays an affectionate promiscuity which is the characteristic of women with intellectual disability." 170*

87. In the case of *Re S*,<sup>171</sup> sterilised at the age of 12 and described as having a 'mental age of no greater than 1 year old' with 'no prospect of any improvement in her already severely retarded mental state', the judge stated:

*'Although I agree that the risk of pregnancy, on its own, is not of sufficient likelihood as to indicate a need to submit her to a sterilisation procedure I would not dismiss the probability of sexual intercourse occurring'.*

*"...since the onset of sexual maturity she displays an affectionate promiscuity which is the characteristic of women with intellectual disability." 170*

# RATIONALE

88. Sterilisation as a 'valid' reason for prevention of sexual abuse also emerges as a strong theme in analysis of public commentary on the issue of sterilisation of disabled women and girls in Australia, as evidenced by these recent examples of public responses to newspaper articles on the issue:

*"My mother worked with profoundly retarded young adults some years ago and saw how easily several were 'taken advantage of' - she knew of three girls who were made pregnant by one repugnant ward assistant and they had to have abortions. I believe that all severely mentally retarded young females should be sterilised if nothing other than to protect them from assault - it does happen."*<sup>172</sup>

*"This happened to my sister who is profoundly disabled 15 years ago and was not the big deal that this seems to be now. have we gone backwards in 15 years. our decision to do this was less about menstrual [sic] cycles and more about some sicko taking advantage of her and her having a child she was unable to look after."*<sup>173</sup>

*"It is also important to consider the possibility that this girl could be sexually assaulted and fall pregnant. If she cannot talk and is not able to communicate to anyone what has happened, her pregnancy may not be discovered until it is too late to consider options such as abortion. Surely this situation would be far more traumatic for Angela, as well as for her parents, than undergoing a hysterectomy."*<sup>174</sup>

*"Considering the possibility of some sicko taking advantage of this girl who could not give consent, and the possibility of pregnancy from such assault, as well as the easing of this child's other suffering, this was a brave and very wise decision."*<sup>175</sup>

*"Certainly if it helps discomfort go for it and in any case surely a good idea to prevent an unwanted pregnancy at the hands of some other party. That would be an abomination for all."*<sup>176</sup>

# RATIONALE

89. Research has demonstrated that rather than protecting against sexual abuse, forced sterilisation can increase vulnerability to sexual abuse.<sup>177</sup> It is widely acknowledged that sexual abuse of women and girls with disabilities occurs at very high rates in our communities.<sup>178</sup> A young woman who has been sterilised is less likely to be taught about sexuality or sexual abuse because she cannot become pregnant. Sterilisation can also inadvertently serve to cover up the sexual abuse of women with disabilities, since pregnancy is often the only clear evidence that sexual abuse has occurred. Others may know she has been sterilised and she may be seen as a safe target. On the other hand women who have been sterilised may also be assumed to be non-sexual and therefore not considered for sexual and reproductive health screening.<sup>179</sup>
90. In 1993, [then] Family Court Judge, Justice Warnick rejected an application<sup>180</sup> for sterilisation of Sarah, a 17 year old disabled girl whose parents had sought authorisation for her to be sterilised to prevent her being sexually abused (and potentially becoming pregnant) at a new residential facility she was due to move into. He acknowledged that the parents had “*brought their application, at least in part, in reliance upon the views of ‘responsible professionals’*”. In rejecting the application, Justice Warnick stated:

*‘To make a decision in this case, in favour of sterilisation, would be virtually equivalent to establishing a policy that all females, with profound disabilities resembling those afflicting Sarah, should be sterilised. There is nothing substantial about the risk, nor clearly detrimental to Sarah about pregnancy, which justifies the interference with personal inviolability, unless it be that where there is any risk (as there must always be) sterilisation should occur. I cannot think that such an approach is consistent with human dignity, the fundamental nature of the right to personal inviolability, and the responsibility of the capable for the incapable.’*



# RATIONALE

91. In relation to sterilisation as a justification to avoid the risk of pregnancy as a result of sexual abuse, Justice Brennan, in *In re JWB [“Marion’s Case”]*,<sup>181</sup> said, in part:

*“Depending on the circumstances, the use - or, a fortiori, the exploitation - of the sexual attributes of a female child may entail tragic consequences, yet the risk or even the likelihood of tragic consequences affords no justification for her sterilization. What difference does it make that the risk is occasioned by an intellectual disability?..... To accord in full measure the human dignity that is the due of every intellectually disabled girl, her right to retain her capacity to bear a child cannot be made contingent on her imposing no further burdens, causing no more anxiety or creating no further demands. If the law were to adopt a policy of permitting sterilization in order to avoid the imposition of burdens, the causing of anxiety and the creating of demands, the human rights which foster and protect human dignity in the powerless would lie in the gift of those who are empowered and the law would fail in its function of protecting the weak.”*

*“Where it is desirable to avoid the risk of pregnancy, the risk may be avoidable by means which involve no invasion of the girl’s personal integrity. Those who are charged with responsibility for the care and control of an intellectually disabled girl (by which I mean a female child who is sexually mature) - whether parents, guardians or the staff of institutions - have a duty to ensure that the girl is not sexually exploited or abused. If her disability inclines her to sexual promiscuity, they have a duty to restrain her from exposing herself to exploitation. It is unacceptable that an authority be given for the girl’s sterilisation in order to lighten the burden of that duty, much less to allow for its neglect. In any event, though pregnancy be a possibility, sterilisation, once performed, is a certainty.....Such a situation bespeaks a failure of care, and sterilisation is not the remedy for the failure. Nor should it be forgotten that pregnancy and motherhood may have a significance for some intellectually disabled girls quite different from the significance attributed by other people. Though others may see her pregnancy and motherhood as a tragedy, she, in her world, may find in those events an enrichment of her life.”*

92. Sterilisation will never overcome vulnerability to sexual abuse. Sexual assault is a problem for all women, including young women with intellectual disabilities and it demonstrates the need for the development of targeted and gendered educational, protective behaviour, and violence prevention programs for disabled women and girls. Women and girls with disabilities, like all women and girls, have a human right to live free from violence, abuse, exploitation and neglect.

# RATIONALE

## THE 'BEST INTEREST' ARGUMENT

93. Successive Australian Governments have continued to use the 'best interest' argument to justify the torture of women and girls with disabilities by forced sterilisation, asserting that sterilisation is only ever carried out as a 'last resort' and when it is in the girl or woman's 'best interests'.<sup>182</sup>
94. The best interest approach has, in effect, been used to perpetuate discriminatory attitudes against women and girls with disabilities, and has only served to facilitate the practice of forced sterilisation.<sup>183</sup> When analysing the applications to Courts and Tribunals for sterilisation of disabled women and girls in Australia to date, it is clear that the best interest approach has in reality, very little to do with the young girl or woman, and more to do with the 'best interests' of others, particularly families and caregivers.

*"The interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care." 184*

*"This Court does not find itself in any doubt that the practical lessening of such burdens on the parents, the emotional and psychological relief coming to them from the expected removal, in a final sense, of problems in their daughter's life, and the betterment of the whole of their family circumstances, can only result in a material and significant improvement in the present and long term welfare of the child." 185*

*"The operation would certainly be a social improvement for Angela's mother which in itself must improve the quality of Angela's life." 186*

*"There is evidence in the case which suggests that [the child's older brother] interests have been seriously affected by the long time and intense concentration by his parents on the need to provide special care for his sister..... This is but another example of the requirement of assessing the child's position, not in isolation but in the family context. It is most likely that relieved of the need, to implement, maintain and monitor the sort of programmes envisaged for the child if she does not undergo hysterectomy, his parents can increase and intensify their efforts to increase his quality of life and his psychological development." 187*

# RATIONALE

*"It is probable that H's parents, who clearly are charged with and undertake the day to day onerous responsibility of caring for H may find that task somewhat less onerous if H undergoes a hysterectomy.....The Court accepts that the sole motivation of the parents is the welfare of H. Even so, it is somewhat simplistic to ignore the reality that the parents undertaking the care of a child such as H ought not be obliged to shoulder difficulties and burdens beyond those which are needlessly onerous. The test is not the best interests of the parents but of H, but, assisting her parents to care for H must be seen as realistically enhancing the care H receives and corresponding enjoyment of life which she may expect." <sup>188</sup>*

*"Not only would S be unable to care appropriately for herself it would also be difficult for others to care for her as a result of menstruation." <sup>189</sup>*

*"It is probable that H's parents, who clearly are charged with and undertake the day to day onerous responsibility of caring for H may find that task somewhat less onerous if H undergoes a hysterectomy.....The Court accepts that the sole motivation of the parents is the welfare of H. Even so, it is somewhat simplistic to ignore the reality that the parents undertaking the care of a child such as H ought not be obliged to shoulder difficulties and burdens beyond those which are needlessly onerous. The test is not the best interests of the parents but of H, but, assisting her parents to care for H must be seen as realistically enhancing the care H receives and corresponding enjoyment of life which she may expect." <sup>188</sup>*

# RATIONALE

*"While we're not concerned so much about the abuse side of things now, if she ever went to a group home or any institution we just we want her safe. I don't think there's any guarantees, even though the hysterectomy wouldn't necessarily stop abuse, it might stop the consequences of it, or possible consequences of it and we just feel as well that we're getting that little bit older, Laura's getting quite big, she's hard to handle. She's got a brother and sister and I don't want to leave them the problems. I don't want them to feel that they've got that problem later on, of having to be worried about that sort of thing, they've got their own lives to live".<sup>190</sup>*

*"It is clear upon the evidence that, because of this strong and determined will in this child, all the more difficult because it is unreasoning and because of the child's increasing strength and the fact that the mother is getting older, M will be harder and harder to deal with." <sup>191</sup>*

95. The UN Committee on the Rights of the Child (CRC) has made it clear that the principle of the 'best interests of the child' cannot be used to justify practices which conflict with the child's human dignity and right to physical integrity:

*"The Committee emphasizes that the interpretation of a child's best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child's human dignity and right to physical integrity. An adult's judgment of a child's best interests cannot override the obligation to respect all the child's rights under the Convention." <sup>192</sup>*

# RATIONALE

96. The UN Special Rapporteur on Torture has also made it clear that 'best interest' and 'medical necessity' are no justification for forced/involuntary sterilisation of disabled women and girls: <sup>193</sup>

*The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.*

*The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on the grounds of administrative efficiency, behaviour modification or medical necessity.....*

*The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned. This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that..... the administration of non-consensual medication or involuntary sterilization, often claimed as being a necessary treatment for the so-called best interest of the person concerned, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of "good intentions" by medical professionals.*

*The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.*

# RATIONALE

97. In 1986 the Canadian Supreme Court ruled in *Re Eve*<sup>194</sup> that a sterilisation could not be performed on someone who cannot give consent – that no one (not even the Court) can consent on their behalf. This resulted in a blanket prohibition of non-voluntary sterilisation. The court reasoned that it can never *“safely be determined that a procedure such as sterilisation is for the benefit of the person considering the grave intrusion on their rights and the physical damage that ensues from the non-voluntary sterilisation without consent, when compared to the highly questionable advantages that can result.”*
98. In making judgements about best interests it is crucial then, that we are clear about whose best interests are really at stake.<sup>195</sup> We need to be clear about whether ‘best interests’ is judged according to human rights principles or whether the judgement is about the ‘best compromise between the competing interests’ of parents, carers, service providers and policy makers. To really determine ‘best interest’ for women and girls with disabilities it is crucial to focus on the fact that a person will be subjected to an irreversible medical procedure with life-long consequences without free and informed consent.<sup>196</sup>
99. Medical professionals are often very influential in the decision to sterilise disabled women and girls. The propensity of Courts and parents to value medical opinion above all else – and in many cases elevating opinions and assertions to the status of fact – has the effect of reducing the ‘best interests’ of disabled women and girls to the ‘best [and easiest, quickest and cheapest] ways’ of controlling and managing their unruly bodies and ‘behaviour’.<sup>197</sup> Yet these judgements are made from a particular perspective which must be vigorously challenged – that the woman or girl with a disability is essentially the sum of her biology or her psychology and her human right to bodily integrity is less important than controlling her body and her behaviour.<sup>198</sup> As former Justice Michael Kirby pointed out at a recent International Conference on Adult Guardianship:

*‘the fact is that most of the judges charged with this task [determining authorisations for sterilisation of disabled girls and women] were atypical, privileged and elderly males. The rules therefore tended to reflect their gender, class, education, means and life experience.’*<sup>199</sup>





**THE IMPACT**

# THE IMPACT

100. In *Marion's Case*,<sup>200</sup> Justice Brennan, said:

*Human dignity requires that the whole personality be respected: the right to physical integrity is a condition of human dignity but the gravity of any invasion of physical integrity depends on its effect not only on the body but also upon the mind and on self-perception. In assessing the significance of sterilization of a female child, it is erroneous to have regard only to the physical acts of the anaesthetist and surgeon.....and to the physiological consequences. Regard must also be had to the disturbance of the child's mind and the emotional aftermath of the sterilization and a comparison must be made between her self-perception when sterilized and the perception she would have had of herself if she had been permitted to live with her natural functions intact.*

101. However, the blatant disregard for the long-term negative impact and effects of forced sterilisation on women and girls with disabilities is clearly evident in the cases that have proceeded to legal judgment in Australia, where, the opinion of the medical specialist is 'authoritative' and sterilisation is characterised as a 'simple' and 'common' procedure. In a technical sense it is portrayed as inconsequential and of minimum risk. In a social sense (from a medical perspective) it offers a final solution to a myriad of problems potentially encountered because of disability.<sup>201</sup> The social and psychological effects on the disabled female are deemed irrelevant:

*"There is unlikely to be any psychological impact of the procedure on H as she has no understanding of the nature of the procedure."* <sup>202</sup>

*"The longer term consequences are less relevant despite the irreversibility of the procedure because as I have earlier mentioned, Angela is never going to have the benefits of a normal teenage and adult life."* <sup>203</sup>

*"There would be no long-term social or psychological effects of hysterectomy."* <sup>204</sup>

102. Crucially, the voices of the women and girls with disabilities who have been the subject of these applications, judgements, laws and debates, have not been heard.

*"The longer term consequences are less relevant despite the irreversibility of the procedure because as I have earlier mentioned, Angela is never going to have the benefits of a normal teenage and adult life."* <sup>203</sup>

# THE IMPACT

103. It is widely recognised that whatever the context, forced sterilisation has long lasting physical and psychological effects, permanently robbing women of their reproductive capabilities and causing severe mental pain and suffering, extreme psychological trauma, including depression and grief.<sup>205</sup> The removal of such a basic bodily function as the ability to reproduce seriously disrupts women's physical well-being and violates their physical integrity and bodily autonomy. As highlighted by Sifris:<sup>206</sup>

*In the context of sterilising people with intellectual disabilities, studies suggest that many people with an intellectual disability understand the effects of sterilisation, maintain negative feelings towards the procedure, and (as occurs in people without an intellectual disability) exhibit signs of 'depression, sexual insecurity, symbolic castration and regret over loss of child-bearing ability.' Further, the view has been expressed that most people with an intellectual disability 'can understand the implications of sterilization' and that 'sterilizing mentally handicapped people [sic] against their will can produce serious and significant psychological damage.' In addition, sterilisation of women with intellectual disabilities has also been associated with loss of self-esteem, increased anxiety, degraded status and perception of the self as deviant.*

104. Women with disabilities have spoken<sup>207</sup> about forced sterilisation as a life sentence, as loss and betrayal, and of the health effects they can anticipate:

*"I was devastated when my doctor advised me that the previous surgeon had done more than tie my tubes. He had actually removed parts of my reproductive system that could never be replaced.....I was shocked and furious."*

*"Because I have had important parts of my body taken away it is hard to find out what is really going on in my body."*

*"We have the right to control what happens to our own bodies."*

*"I was devastated when my doctor advised me that the previous surgeon had done more than tie my tubes. He had actually removed parts of my reproductive system that could never be replaced.....I was shocked and furious."*

# THE IMPACT

*"Because I will not go through obvious menopause, in my culture that means I have no marker for becoming an 'elder'."*

*"Surgery of a healthy body is mutilation."*

*"I am...taking a big risk on behalf of myself and my family in speaking up. I would like to know what is being done for us who have had this done twenty or thirty years ago? I don't have an intellectual disability and it was done before I started having a period. What research is being done to help us who were young children that went through this, and when we go through menopause? It can affect our health in the future. I think of this as my real disability – the physical one that you see isn't real – the one I had happen to me when I was 12 is the main one and I don't have anyone to turn to."*

*"It has resulted in loss of my identity as a woman, as a sexual being."*

*"I have been denied the same joys and aspirations as other women."*

*"It stops us from having children if we want to."*

*"I worry about the future health effects like osteoporosis and other problems."*

*"The fact that services are not there is no reason for sterilisation."*

*"Sterilisation takes my choice away."*

*"I'm angry."*

*"I want to experience a period."*

*"Because I will not go through obvious menopause, in my culture that means I have no marker for becoming an 'elder'."*

# THE IMPACT

*"Sterilization is a terrible thing to do to a woman. They had no right to do that to me. They never ask you about it. They told me that it was just for my appendix and then they did that to me."*

*"If they'd told the truth and asked me, I would have shouted 'No!' My sterilisation makes me feel I'm less of a woman when I have sex because I'm not normal down there..... When I see other mums holding their babies, I look away and cry because I won't ever know that happiness."*

*"Sterilisation takes away your womanhood."*

*"I do want to have children but I can't now."*

*"I got sterilised at 18, my mum said I had to – she said that if I ever had a child, she'd probably have to help look after it. She said: "I went through hell bringing you up and I will not do it again". It's more than 30 years now since I was sterilised and the pain is still unspeakable. It is the biggest regret of my life."*

*"For me it has meant a denial of my womanhood."*

*"I was sterilised and I wasn't ever told when I was getting it done. The specialist told mum about it but I didn't know I'd had it done until I was 18."*

*"I have always had a fear of speaking out about it – it's been very isolating."*

*"I want to help others who don't have a voice, to stop it happening to them – I feel powerless to do that."*

*"I got sterilised at 18, my mum said I had to – she said that if I ever had a child, she'd probably have to help look after it. She said: "I went through hell bringing you up and I will not do it again". It's more than 30 years now since I was sterilised and the pain is still unspeakable. It is the biggest regret of my life."*

# THE IMPACT

*"I will have no way of knowing about the onset of my menopause."*

*"I know it has resulted in hormone changes in my body that wouldn't have happened otherwise."*

*"It can lead to the break-up of relationships."*

*"I was what I call, 'socially sterilised' – I had the operation when I was a young woman because growing up I had been brainwashed to believe that disabled women like me can't be mothers. I would have loved to be a mother. There are of course, no proper words to describe the loss, the guilt, the regret and the pain I feel every day."*

*"Other people don't understand what it means in your life and it's very hard to explain that to people."*

*"Other women don't understand what its like for us – it sets us apart from them."*

*"For me it is about living with loss."*

*"It really affects my self esteem."*

*"It has stopped me having a normal life."*

*"Its about loss of control."*

*"For me it has meant a loss of trust – especially of doctors – those who women with disabilities often have to place their trust."*

*"I have a blockage of emotions."*

*"For me it has meant a loss of trust – especially of doctors – those who women with disabilities often have to place their trust."*



# THE IMPACT

*"It's a great emotional upheaval."*

*"I feel alone and isolated."*

*"The pain is hard to bear."*

*"I have a fear of not being seen as a sexual identity – of sexual rejection."*

*"I have feelings of rejection."*

*"There is no information available for us."*

*"There are not enough services or people to listen."*

105. Women with disabilities have also spoken<sup>208</sup> about what needs to happen to enable healing to take place for those already affected, and for safeguards to be put in place to prevent others from experiencing this form of torture and from being denied their fundamental human rights:

*"There needs to be better explanations for women."*

*"We need to be given more information about our body."*

*"We need to have information about the whole process and what it means so that we can make an informed choice."*

*"We need to build a data base on health issues specifically for women who have been sterilised."*

*"It time people started to listen! And do what we want."*

*"We need to have information about the whole process and what it means so that we can make an informed choice."*

# THE IMPACT

*"It's absolutely necessary to empower women with disabilities to make decisions."*

*"Let us be in charge of our own bodies."*

*"Women with disabilities need to have more involvement in the investigation stage so we can say what we want."*

*"We need to start support groups for women who this has happened to."*

*"We have to encourage self-advocacy – help women with intellectual disability to say what they want in their lives."*

*"We have to provide individuals with proper support to make the right decision for them."*

*"Educate professionals especially doctors and support workers so that they understand how it can affect our lives."*

*"We must change doctors' attitudes."*

*"It is important that we educate the appropriate people to listen to women with disabilities in the investigation process."*

*"We need to see a change in attitude."*

*"We have to publicise the issue through public seminars and debates."*

*"We must help services listen better to the issues for women with disabilities."*

*"We need to educate all the services that have a role to play in making this happen."*

*"It is important that we educate the appropriate people to listen to women with disabilities in the investigation process."*

# THE IMPACT

*"We need to educate the community, to get them to see it is about the lives of women with disabilities."*

*"We need to be changing education at all levels."*

*"We have to break the silence about what has happened."*

*"We must make sure the voices of women with disabilities are heard at international and UN conventions."*

*"We have to change the law so that it stops happening."*

*"We need to send a message to politicians that sterilisation is about women with disabilities and how they live their lives."*

106. For women with disabilities, the issue of forced sterilisation encompasses much broader issues of reproductive health, including for example: support for choices and services in menstrual management, contraception, abortion, sexual health management and screening, pregnancy, birth, parenting, menopause, sexuality, violence prevention and more. Research has clearly shown that, particularly for women with intellectual disabilities, attitudes toward sexual expression remain restrictive. Women with disabilities express desires for intimate relationships but report limited opportunities and difficulty negotiating relationships. Sexual knowledge in women with disabilities, particularly those with intellectual disabilities, has been shown to be poor and access to education limited. In addition, laws addressing sexual exploitation may be interpreted as prohibition of relationships.<sup>209</sup> Women with disabilities have spoken<sup>210</sup> about the impact of all these issues on their lives, for example:

*"In (my institution) you were not allowed to be with a man. You got into trouble. It's not right."*

*"Persons who reside in institutions are being denied their basic human rights to freedom, privacy and sexuality."*

*"We need to send a message to politicians that sterilisation is about women with disabilities and how they live their lives."*

# THE IMPACT

*"I'm not allowed to have a boyfriend."*

*"We want information about relationships and having babies."*

*"Is menstrual flow any more of a problem than incontinence?"*

*"I have known of cases where girls have been given the wrong information by cruel nursing staff and have spent years thinking they are incapable of having intercourse, much less bearing a child."*

*"A strange man once tried to kiss me in a lift. I said "please don't do that". I should have hit him, or told him to fuck off, but I have had my disability all my life, and I have been taught well not to be angry when my personal space, my body, my emotional integrity have been violated. So I said "please don't do that" and later I cried....."*

*"Disabled people are just not seen as sexual beings with sexual needs and feelings."*

*"Many women with disabilities who are raped are too scared to go to the police in case they will not be believed."*

*"People don't tell us about sex."*

*"Jean lived in the dormitory next door to mine. She was going with her boyfriend, Simon, who lived in a separate part of the same institution and was sometimes permitted to go across the courtyard to visit him. One day, they were caught petting in a seldom-used back room and they were forbidden to see each other thereafter. They were both over the legal age of consent and were doing nothing wrong by normal social standards."*

*"I have known of cases where girls have been given the wrong information by cruel nursing staff and have spent years thinking they are incapable of having intercourse, much less bearing a child."*

# THE IMPACT

*"It seems that periods are sometimes suppressed for the convenience of care givers, support persons and services."*

*"If you go in a group home that's run by like, a religious organisation, you're not allowed to have a boy come over. You're not allowed to even kiss a boy let alone have sex. If you wanted to have sex you would have to go maybe to the park or somewhere."*

*"There is a glaring lack of in-home assistance and support for families supporting a woman learning about menstruation."*

*"Having your period gives a context for others to decide why you have to be on contraceptives."*

*"Sexuality is not just sexual intercourse. It is much, much more than just the physical act of having sex. Our sexuality is as much a part of us as our clothes-sense, our favourite foods and our personal style. Our need to love and be loved is as vital to our wellbeing as our need to eat, drink and breathe. To deny our sexuality is to deny that we are whole human beings."*

*"Sexuality within institutional accommodation should not even be an issue. Privacy and freedom are not privileges to be granted or taken away. They are our basic human rights. Just as people who run the institutions would not appreciate their own sex life to be regulated by a stranger, nor do we. What we do in our own rooms, and who we do it with, is not the business of staff, administration the milkman, or anyone else."*

*"Sexuality is not just sexual intercourse. It is much, much more than just the physical act of having sex. Our sexuality is as much a part of us as our clothes-sense, our favourite foods and our personal style. Our need to love and be loved is as vital to our wellbeing as our need to eat, drink and breathe. To deny our sexuality is to deny that we are whole human beings."*



# **VIOLATION**



# VIOLATION OF HUMAN RIGHTS

## FORCED STERILISATION AS A VIOLATION OF HUMAN RIGHTS

107. Since 2005, United Nations treaty monitoring bodies have consistently and formally recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.<sup>211</sup> Successive Australian Governments have to date, failed to do so, despite the current Government's assertion that:

*Australia is proud of its historical role in the drafting and development of international human rights instruments. Government initiatives since 2007 demonstrate its commitment to engaging with the UN and affirm Australia's longstanding commitment to the international protection of human rights.... The Government expects public sector officials to act consistently with international treaties to which Australia is a party....*<sup>212</sup>

108. The Australian Government is in violation of international human rights law by allowing women and girls with disabilities to be sterilised in the absence of their free and informed consent. Among the fundamental rights governments are required to respect, protect, and fulfill are: the right to be free from torture, and cruel, inhuman, or degrading treatment or punishment; the right to the highest attainable standard of physical and mental health; the right to life, liberty, and security of person; the right to equality; the right to non-discrimination; the right to be free from arbitrary interference with one's privacy and family; and the right to marry and to found a family.<sup>213</sup>
109. Forced sterilisation clearly breaches every international human rights treaty and declaration to which Australia is a party.

# VIOLATION OF HUMAN RIGHTS

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

110. The *Convention on the Rights of Persons with Disabilities* (CRPD), ratified by Australia in 2008, offers the most comprehensive and authoritative set of standards on the rights of people with disabilities. Its fundamental purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.<sup>214</sup>
111. The CRPD mandates States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others. This means that an individual's right to decision-making cannot be substituted by decision-making of a third party, but that each individual without exception has the right to make their own choices and to direct their own lives, whether in relation to living arrangements, medical treatment, or family relationships.
112. Among other things, the CRPD also mandates States Parties to: protect persons with disabilities from violence, exploitation and abuse (including the gender-based aspects of such violations); ensure that persons with disabilities are not subjected to arbitrary or unlawful interference with their privacy and family, including in all matters relating to marriage, family, parenthood and relationships; guarantee persons with disabilities, including children, the right to retain their fertility; take measures to ensure women and girls enjoy the full and equal enjoyment of their human rights; prevent people with disabilities from being subject to torture, or cruel, inhuman or degrading treatment or punishment; prohibit involuntary treatment and involuntary confinement; and, ensure the right of people with disabilities to the highest attainable standard of health without discrimination.
113. The *Committee on the Rights of Persons with Disabilities*<sup>215</sup> has clearly identified that forced and coerced sterilisation of women and girls with disabilities (as well as discrimination in other areas of their reproductive rights) is in clear violation of multiple provisions of the CRPD.

# VIOLATION OF HUMAN RIGHTS

114. In its *Concluding Observations on Spain*,<sup>216</sup> the CRPD Committee expressed its concern that ‘persons with disabilities whose legal capacity is not recognized may be subjected to sterilization without their free and informed consent’. It urged the State party to abolish the administration of medical treatment, in particular sterilization, without the full and informed consent of the patient; and ensure that national law especially respects women’s rights under articles 23 and 25 of the Convention. The Committee also urged the State party to ensure that the informed consent of all persons with disabilities is secured on all matters relating to medical treatment; and made several recommendations regarding the need to address violence against women with disabilities and children.
115. In its 2012 *Concluding Observations on Peru*,<sup>217</sup> the CRPD Committee expressed its deep concern at the forced sterilisation of people with ‘mental disabilities’ and urged the State party to abolish administrative directives on forced sterilization of persons with disabilities. It also made strong recommendations for the State party to take action to replace regimes of substitute decision-making by supported decision-making, ‘which respects the person’s autonomy, will, and preferences’. The need to accelerate efforts to eradicate and prevent discrimination against women and girls with disabilities, was also recommended.
116. In late September 2012, the CRPD Committee released its *Concluding Observations on China*,<sup>218</sup> expressing its deep concern at the practice of forced sterilization and forced abortion on women with disabilities without free and informed consent, and calling on the State party to revise its laws and policies in order to prohibit these practices. The Committee also made strong recommendations around the prevention of violence against disabled women and girls, in particular the incidents of women and girls with intellectual disabilities being subjected to sexual violence. In addition, the Committee urged the state party to adopt measures to repeal the laws, policies and practices which permit guardianship and trusteeship for adults and take legislative action to replace regimes of substituted decision-making by supported decision making.
117. In its *Concluding Observations on Hungary*,<sup>219</sup> in 2012, the CRPD Committee called upon the State party to take appropriate and urgent measures to protect persons with disabilities from forced sterilisation, to take appropriate measures to enable men and women with disabilities who are of marriageable age to marry and found a family, and to adopt measures to ensure that health care services are based on the free and informed consent of the person concerned. It also recommended that the State party take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, including with respect to the individual’s right, on their own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence. The need to address and prevent multiple forms of discrimination of women and girls with disabilities, including violence and abuse, were also recommended.

# VIOLATION OF HUMAN RIGHTS

118. In its *Concluding Observations on Tunisia*,<sup>220</sup> the CRPD Committee expressed its concern the lack of clarity concerning the scope of legislation to protect persons with disabilities from being subjected to treatment without their free and informed consent, and specifically recommended the ‘*State party incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women’s rights under article 23 and 25 of the Convention.*’ The Committee also recommended that the State party design and implement awareness-raising campaigns and education programmes throughout society....on women with disabilities in order to foster respect for their rights and dignity; combat stereotypes, prejudices and harmful practices; and promote awareness of their capabilities and contributions.

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

119. Australia ratified the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT) in 1989. CAT emphasises that gender is a key factor in implementation of the Convention.<sup>221</sup> Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination.<sup>222</sup> The right to be free from torture and cruel, inhuman or degrading treatment or punishment carries with it non-derogable state obligations to prevent, punish, and redress violations of this right.

# VIOLATION OF HUMAN RIGHTS

120. Forced sterilisation constitutes torture.<sup>223</sup> The UN Special Rapporteur on Torture has clarified that forced sterilisation satisfies the definition of torture contained in Article 1 of the CAT,<sup>224</sup> and has emphasised that forced sterilisation constitutes a crime against humanity when committed as part of a widespread or systematic attack directed against any civilian population.<sup>225</sup> In February 2013, (as outlined earlier in this paper), the UN Special Rapporteur on Torture clarified that:

*Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.*<sup>226</sup>

121. In reviewing States parties compliance with CAT, the Committee Against Torture is increasingly recognising forced sterilisation and medical interventions on people with disabilities in the absence of their free and informed consent, as violations of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.

*Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.*<sup>226</sup>

# VIOLATION OF HUMAN RIGHTS

122. In its 2013 *Concluding Observations on Peru*,<sup>227</sup> the Committee Against Torture recommended that the State party accelerate all current investigations related to forced sterilization, initiate prompt, impartial and effective investigations of all similar cases and provide adequate redress to all victims of forced sterilization. In addition, it recommended that State party urgently repeal the suspended administrative decree which allows the forced sterilization of persons with mental disabilities.
123. The Committee Against Torture's *Concluding Observations of the Czech Republic*,<sup>228</sup> in 2012, dealt in detail with the issue of forced sterilisation. It recommended that the State party investigate promptly, impartially and effectively all allegations of involuntary sterilization of women, extend the time limit for filing complaints, prosecute and punish the perpetrators and provide victims with fair and adequate redress, including adequate compensation and rehabilitation.
124. In its 2009 *Concluding Observations on Slovakia*,<sup>229</sup> the Committee Against Torture recommended that the State party take urgent measures to investigate promptly, impartially, thoroughly, and effectively, allegations of involuntary sterilisation of women, prosecute and punish the perpetrators, and provide the victims with fair and adequate compensation.

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)

125. Australia made a formal agreement to be legally bound by the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) in 1983, and in so doing, became legally obliged to respect, protect, promote and fulfil the right to non-discrimination for women and to ensure the achievement of equality between men and women. CEDAW requires States parties to take additional, special measures for women subjected to multiple forms of discrimination, including women and girls with disabilities.<sup>230</sup>
126. CEDAW specifically provides for a proper understanding of maternity as a social function, access to family planning information, and the elimination of discrimination against women in marriage and family relations. Furthermore, CEDAW mandates that women be provided the same rights to decide freely on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights.<sup>231</sup>



# VIOLATION OF HUMAN RIGHTS

127. The CEDAW Committee has clearly articulated the link between forced sterilisation and violation of the right to reproductive self-determination noting that '*compulsory sterilization...adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children*'.<sup>232</sup> In addition, the Committee characterises forced sterilisation as a form of violence against women, and directs States to ensure that forced sterilisations do not occur.<sup>233</sup>
128. In its 2012 *Concluding Observations on Chile*,<sup>234</sup> the CEDAW Committee expressed its concern about reported cases of involuntary sterilization of women, and recommended that the State party ensure that fully informed consent is systematically sought by medical personnel before sterilizations are performed, that practitioners performing sterilizations without such consent are sanctioned and that redress and financial compensation are available for women victims of non-consensual sterilization. The Committee also recommended that the State party provide adequate access to family planning services and contraceptives.
129. The CEDAW Committee's *Concluding Observations on Jordan*,<sup>235</sup> in 2012, clearly detailed the Committee's ongoing concern at the practice of forced sterilisation of women and girls with 'mental disabilities', as well as its concern at the absence of a comprehensive law protecting women with mental disabilities from forced sterilization. The Committee urged the State party to adopt a comprehensive law protecting women, in particular girls with mental disabilities, from forced sterilization, and to ensure that the State party intensify its efforts in providing social and health services support to families with girls and women with disabilities.
130. In its 2012 *Concluding Observations on Comoros*,<sup>236</sup> the CEDAW Committee recommended that the State party put in place a comprehensive strategy to eliminate harmful practices and stereotypes that discriminate against women, and that such a strategy should include concerted efforts to educate and raise public awareness about this subject.
131. As highlighted elsewhere in this paper, in 2010, the CEDAW Committee expressed concern in its *Concluding Observations on Australia*<sup>237</sup> at the ongoing practice of non-therapeutic sterilisations of women and girls with disabilities and recommended that the Australian Government enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.

# VIOLATION OF HUMAN RIGHTS

132. In its *Concluding Observations on the Czech Republic*<sup>238</sup> in 2010, the CEDAW Committee made detailed recommendations regarding forced sterilisation of women with disabilities. The Committee urged the State party to: adopt legislative changes clearly defining the requirements of free, prior and informed consent with regard to sterilizations, in accordance with relevant international standards, including a period of at least seven days between informing the patient about the nature of the sterilization, its permanent consequences, potential risks and available alternatives and the patient's expression of her free, prior and informed consent; review the three-year time limit in the statute of limitations for bringing compensation claims in cases of coercive or non-consensual sterilizations in order to extend it and, as a minimum, ensure that such time limit starts from the time of discovery of the real significance and all consequences of the sterilization by the victim rather than the time of injury; consider establishing an ex gratia compensation procedure for victims of coercive or non-consensual sterilizations whose claims have lapsed; provide all victims with assistance to access their medical records; and investigate and punish illegal past practices of coercive or non-consensual sterilizations. The Committee further recommended that the State party adopt a law on women's reproductive rights; that clarified that all interventions are performed only with the woman's free, prior and informed consent. Mandatory training for all health professionals on women's reproductive rights and related ethical standards was also recommended.
133. In 2006, the CEDAW Committee issued a view finding Hungary in violation of the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), for its failure to protect the reproductive rights of Ms. Andrea Szijarto, a Hungarian Romani woman was subjected to coerced sterilisation by medical staff at the public hospital in Fehérgyarmat.<sup>239</sup> The CEDAW Committee found that the 'failure of the State party, through the hospital personnel, to provide appropriate information and advice on family planning' constituted a violation of Articles 10, 12, and 16 of CEDAW. Similarly, the State of Hungary was responsible for the hospital's failure to obtain informed consent and the deprivation of the woman's right to decide the number and spacing of her children in violation of CEDAW.<sup>240</sup> Therefore, the CEDAW Committee held the State of Hungary responsible for an involuntary sterilisation procedure performed in one of its public hospitals. The Committee subsequently recommended that Hungary provide Ms. Szijarto with appropriate compensation. More generally, the Committee recommended that Hungary:

*'take further measures to ensure that the relevant provisions of the Convention and the pertinent paragraphs of the Committee's general recommendations Nos. 19, 21 and 24...are known and adhered to by all relevant health professionals; review domestic law on informed consent in sterilization cases and ensure conformity with international standards; and monitor health centres performing sterilizations so as to ensure fully informed consent is being given, with sanctions in place for breaches.'*

The decision marks the first time that an international human rights body in an individual complaint has held a government accountable for failing to provide necessary information to a woman to enable her to give informed consent to a reproductive health procedure.<sup>241</sup>

# VIOLATION OF HUMAN RIGHTS

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR)

134. The *International Covenant on Civil and Political Rights* (ICCPR) ratified by Australia in 1980, commits its parties to respect the civil and political rights of individuals, including the right to life, freedom of religion, freedom of speech, freedom of assembly, family rights, electoral rights and rights to due process and a fair trial. Article 3 implies that all human beings should enjoy the rights provided for in the Covenant, on an equal basis and in their totality.
135. The *Human Rights Committee*, responsible for the monitoring of the ICCPR, has clarified to State parties that forced sterilisation is in contravention of Articles 7, 14, 17 and 24 of the ICCPR.<sup>242</sup> More than 14 years ago, the Human Rights Committee identified the forced sterilisation of disabled women as being in contravention of the ICCPR. In its 1999 *Concluding Observations on Japan*,<sup>243</sup> the Committee expressed its regret that the law had not provided for a right of compensation to women with disabilities who were subjected to forced sterilization, and recommended that the necessary legal steps be taken in this regard.
136. In its 2012 *Concluding Observations on Lithuania*,<sup>244</sup> the Human Rights Committee expressed its concern at the potential negative consequences of the courts' authority to authorise procedures such as abortion and sterilisation to be performed on disabled women deprived of their legal capacity.
137. In 2011, in its review of *Slovakia's*<sup>245</sup> report under the ICCPR, the Human Rights Committee stated its regret at the lack of information on concrete measures to eliminate forced sterilisation, and recommended the State Party ensure that all procedures are followed in obtaining the full and informed consent of women who seek sterilisation services. It further recommended that special training for health personnel aimed at raising awareness about the harmful effects of forced sterilization, be introduced.
138. As outlined earlier in this paper, the Human Rights Council requires the Australian Government to address the issue of forced sterilisation in Australia's upcoming review under the ICCPR.<sup>246</sup> Specifically, the Human Rights Council has asked the Australian Government to:

*Please provide information on whether sterilization of women and girls, including those with disabilities, without their informed and free consent, continues to be practiced, and on steps taken to adopt legislation prohibiting such sterilisations.*

# VIOLATION OF HUMAN RIGHTS

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE CONVENTION ON THE RIGHTS OF THE CHILD (CRC)

139. Australia ratified the *Convention on the Rights of the Child* (CRC) in 1990. The CRC generally defines a child as any human being under the age of eighteen years, and requires States parties to ensure that all children within their jurisdiction enjoy all the rights enshrined in the Convention without discrimination of any kind. The CRC recognises that children with disabilities belong to one of the most marginalised groups of children, and that factors such as gender can increase this vulnerability.<sup>247</sup> The CRC specifically recognises that:

*Girls with disabilities are often even more vulnerable to discrimination due to gender discrimination. In this context, States parties are requested to pay particular attention to girls with disabilities by taking the necessary measures, and when needed extra measures, in order to ensure that they are well protected, have access to all services and are fully included in society.*<sup>248</sup>

140. The *Committee on the Rights of the Child* has expressly identified forced sterilisation of girls with disabilities as a form of violence and clearly articulates that all forms of violence against children are unacceptable without exception.<sup>249</sup> It has advised that State parties to the CRC are expected to prohibit by law the forced sterilisation of children with disabilities,<sup>250</sup> and made it very clear that the principle of the “best interests of the child” cannot be used to justify practices which conflict with the child’s human dignity and right to physical integrity.<sup>251</sup>

*Girls with disabilities are often even more vulnerable to discrimination due to gender discrimination. In this context, States parties are requested to pay particular attention to girls with disabilities by taking the necessary measures, and when needed extra measures, in order to ensure that they are well protected, have access to all services and are fully included in society.*<sup>248</sup>

# VIOLATION OF HUMAN RIGHTS

141. In 2006, the Committee on the Rights of the Child expressed its deep concern about *'the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities'*, and emphasised that forced sterilisation *'seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects'*.<sup>252</sup>
142. In June 2012, the Committee on the Rights of the Child, in its *Concluding Observations on Australia*<sup>253</sup> expressed its serious concern that the absence of legislation prohibiting non-therapeutic sterilisation of girls and women with disabilities is discriminatory and in contravention of the CRC. The Committee urged the State party to: *'Enact non-discriminatory legislation that prohibits non-therapeutic sterilization of all children, regardless of disability; and ensure that when sterilisation that is strictly on therapeutic grounds does occur, that this be subject to the free and informed consent of children, including those with disabilities.'* Furthermore, the Committee clearly identified non-therapeutic sterilisation as a form of violence against girls and women, and recommended that the Australian Government develop and enforce strict guidelines to prevent the sterilisation of women and girls who are affected by disabilities and are unable to consent.
143. In its *Concluding Observations on Australia*<sup>254</sup> in 2005, the Committee on the Rights of the Child, recommended that Australia: *'prohibit the sterilisation of children, with or without disabilities...'*<sup>255</sup>
144. In 1999, the Committee on the Rights of the Child expressed its regret that *'forced sterilization of mentally disabled children is legal with parental consent'* in *Austria*,<sup>256</sup> and recommended that existing legislation be reviewed in accordance with the provisions of the Convention, especially articles 3 and 12.

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (CESCR)

145. The *International Covenant on Economic, Social and Cultural Rights* (CESCR) was ratified by Australia in 1975. The CESCR commits States Parties to work toward the granting of economic, social, and cultural rights to individuals, including labour rights and rights to health, education, and an adequate standard of living. The CESCR protects human rights that are fundamental to the dignity of every person. In particular, Article 3 of this Covenant provides for the equal right of men and women to the enjoyment of rights it articulates, and this is a mandatory and immediate obligation of States parties.<sup>257</sup>

# VIOLATION OF HUMAN RIGHTS

146. The Committee on Economic, Social and Cultural Rights (CESCR) has made it clear that forced sterilisation of girls and women with disabilities is in breach of Article 10 of the *Convention on Economic, Social, and Cultural Rights*:<sup>258</sup>

*'persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood'. The needs and desires in question should be recognized and addressed in both the recreational and the procreational contexts. These rights are commonly denied to both men and women with disabilities worldwide. Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2).'*

147. The Committee on Economic, Social and Cultural Rights (CESCR) has also made it clear that:

*Article 10 also implies, subject to the general principles of international human rights law, the right of persons with disabilities to marry and have their own family..... States parties should ensure that laws and social policies and practices do not impede the realization of these rights. Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy.<sup>259</sup>*

*'persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood'. The needs and desires in question should be recognized and addressed in both the recreational and the procreational contexts. These rights are commonly denied to both men and women with disabilities worldwide. Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2).'*



# VIOLATION OF HUMAN RIGHTS

148. The right to sexual and reproductive health is an integral component of the right to health. The CESCR emphasises aspects of the right to sexual and reproductive health in Article 12. The UN Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, have made it very clear that States have an obligation to respect, protect and fulfil the right to health of all individuals, including those with disabilities, and have recognised that forced sterilisation of women and girls with disabilities is inherently inconsistent with their sexual and reproductive health rights and freedoms, violates their right to reproductive self-determination, physical integrity and security, and injures their physical and mental health.<sup>260</sup>
149. In 2009, the United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental health, re-iterated that the existence of a disability is not a lawful justification for any deprivation of liberty, including denial of informed consent. The Special Rapporteur made it clear that policies and legislation sanctioning non-consensual treatments lacking therapeutic purpose or aimed at correcting or alleviating a disability, including sterilisations, abortions, electro-convulsive therapy and unnecessarily invasive psychotropic therapy, violate the right to physical and mental integrity and may constitute torture and ill-treatment.<sup>261</sup> He clarified that:

*'informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.' States must provide persons with disabilities equal recognition of legal capacity, care on the basis of informed consent, and protection against non-consensual experimentation; as well as prohibit exploitation and respect physical and mental integrity.'*<sup>262</sup>

# VIOLATION OF HUMAN RIGHTS

150. In 2011, Mr Anand Grover, UN Special Rapporteur [on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health], in his report on the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health, stated:

*'The use of.....coercion by the State or non-State actors, such as in cases of forced sterilization, forced abortion, forced contraception and forced pregnancy has long been recognized as an unjustifiable form of State-sanctioned coercion and a violation of the right to health. Similarly, where the..... law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual.....the use by States of criminal and other legal restrictions to regulate sexual and reproductive health may represent serious violations of the right to health of affected persons and are ineffective as public health interventions. These laws must be immediately reconsidered. Their elimination is not subject to progressive realization since no corresponding resource burden, or a de minimis one, is associated with their elimination.'*<sup>263</sup>

*'The use of.....coercion by the State or non-State actors, such as in cases of forced sterilization, forced abortion, forced contraception and forced pregnancy has long been recognized as an unjustifiable form of State-sanctioned coercion and a violation of the right to health. Similarly, where the..... law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual.....the use by States of criminal and other legal restrictions to regulate sexual and reproductive health may represent serious violations of the right to health of affected persons and are ineffective as public health interventions. These laws must be immediately reconsidered. Their elimination is not subject to progressive realization since no corresponding resource burden, or a de minimis one, is associated with their elimination.'*<sup>263</sup>

# VIOLATION OF HUMAN RIGHTS

## FORCED STERILISATION OF PERSONS WITH DISABILITIES VIOLATES THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION (ICERD)

151. The *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) was one of the first human rights treaties to be adopted by the United Nations, and was ratified by Australia in 1975.<sup>264</sup> As its title suggests, the ICERD commits its members to the elimination of racial discrimination and the promotion of understanding among all races.
152. The Committee on the Elimination of All Forms of Racial Discrimination (CERD) pays special attention to cases where such multiple forms of discrimination are involved. Regarding the intersectionality of gender, CERD has emphasised that racial discrimination does not always affect women and men equally or in the same way, and certain forms of racial discrimination directly affect women - such as forced and coerced sterilisation of indigenous women,<sup>265</sup> or sexual violation against women of particular racial or ethnic groups. At the same time, racial discrimination may have consequences where women are primarily or exclusively affected (e.g. racial bias-motivated rape). Against this backdrop the Committee has been enhancing its efforts to integrate a gender perspective into its work and also recommending that States parties provide disaggregated data with regard to the gender dimensions of racial discrimination as well as to take necessary actions in this regard.<sup>266</sup>
153. In its *Concluding Observations on Mexico*<sup>267</sup> in 2006, the Committee on the Elimination of All Forms of Racial Discrimination (CERD), expressed its concern at the alleged practice of forced sterilization indigenous men and women in Chiapas, Guerrero and Oaxaca, and urged the State party to take all necessary steps to put an end to practices of forced sterilization, and to impartially investigate, try and punish the perpetrators of such practices. It also recommended that the State party ensure that fair and effective remedies are available to the victims, including those for obtaining compensation.
154. In its *Concluding Observations on Slovakia*<sup>268</sup> in 2004, the ICERD Committee expressed its concern about reports of cases of sterilisation of Roma women without their full and informed consent. The Committee "strongly recommended" that the State party take all necessary measures to put an end to "this regrettable practice.....the State party should also ensure that just and effective remedies, including compensation and apology, are granted to the victims."

# VIOLATION OF HUMAN RIGHTS

## OTHER KEY INTERNATIONAL AND NATIONAL STANDARDS AND FRAMEWORKS

155. The 1994 *International Conference on Population and Development (ICPD) Programme of Action*,<sup>269</sup> affirmed that woman's ability to access reproductive health and rights is cornerstone of her empowerment, and protects the right to decide freely and responsibly the number and spacing of one's children. A total of 179 governments (including Australia) signed up to the ICPD Programme of Action which set out to, amongst other things, provide universal access to family planning and sexual and reproductive health services and reproductive rights. The programme of action and benchmarks added at the ICPD+5 review went on to inform the eight *Millennium Development Goals* (MDG's),<sup>270</sup> of which gender equality is central.
156. The *Beijing Declaration and Platform for Action (BPA)* identifies forced sterilisation as an act of violence and reaffirms the rights of women, including women with disabilities, to found and maintain a family, to attain the highest standard of sexual and reproductive health, and to make decisions concerning reproduction free from discrimination, coercion, and violence.<sup>271</sup> The commitment to the BPA was further reaffirmed by member states in the outcome document of the *Twenty-third Special Session of the UN General Assembly*<sup>272</sup> in 2000. This meant that the Australian Government committed to *further* actions and initiatives to accelerate the implementation of the BPA, particularly in regard to addressing the needs of women and girls with disabilities.
157. *Biwako Plus Five*,<sup>273</sup> a supplement to the *United Nations Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights based Society in Asia and the Pacific (BMF)*,<sup>274</sup> (adopted by the Australian Government in 2002), specifically required Governments to, amongst other things: 'take appropriate measures to address discrimination against women with disabilities in all matters, including those relating to marriage, family, parenthood and relationships, to ensure their full development, advancement and empowerment.'
158. At the domestic level, forced sterilisation of women and girls with disabilities runs contrary to a number of national legislative and policy frameworks and strategies in areas (such as disability, child protection, family violence, human rights and women's health).<sup>275</sup> For example, forced sterilisation meets the definition of family violence as articulated in the *Commonwealth Family Law Legislation*.<sup>276</sup> The *Australian Law Reform Commission* has clarified that forced sterilisation and abortion is a type of family violence experienced by people with disabilities.<sup>277</sup>

# VIOLATION OF HUMAN RIGHTS

## OTHER LEGAL PRECEDENTS: FORCED AND COERCED STERILISATION AS A VIOLATION OF HUMAN RIGHTS

159. The issue of forced sterilisation of women and girls is increasingly being recognised in the Courts as a violation of women's fundamental human rights.
160. In November 2012, the European Court of Human Rights ruled against Slovakia in a case of forced sterilization (*I.G. and Others vs. Slovakia*).<sup>278</sup> The case was lodged with the European Court by three applicants, who were forcibly sterilised in Krompachy Hospital under different circumstances in 1999-2002. Two of the applicants were underage minors at the time of the interventions. The European Court confirmed that forced sterilization – sterilization without an informed consent – represents a serious interference into women's fundamental human rights, guaranteed by the European Convention and other treaties. The European Court ruled in favour of the applicants and ordered the Slovak Government to pay compensation to the applicants and the reimbursement of their legal costs.
161. In November 2011, the European Court of Human Rights delivered its judgement in the case of *V.C. v. Slovakia*.<sup>279</sup> This case concerned a woman from Slovakia who was coercively sterilised in 2000 in the hospital in Prešov (eastern Slovakia). After unsuccessfully claiming her rights on national level, she resorted to the European Court of Human Rights. The Court held that the sterilisation carried out without her informed consent violated her right not to be subject to torture or to inhuman or degrading treatment (Article 3 of the European Convention) and her right to respect for private and family life (Article 8). The Court noted that: “sterilization constitutes a major interference with a person's reproductive health status” and “bears on manifold aspects of the individual's personal integrity, including his or her physical and mental well-being and emotional, spiritual and family life.”<sup>280</sup> The Court held that Slovakia was to pay the applicant 31,000 euros (EUR) in respect of non-pecuniary damage and EUR 12,000 for costs and expenses.
162. In July 2012, in a landmark judgment, the High Court in Windhoek found that the Namibian government had coercively sterilised three HIV-positive women in violation of their basic rights. The case, *H.N. and Others v Government of the Republic of Namibia*<sup>281</sup> involved three HIV-positive women who sought to access pre-natal services at public hospitals in Namibia. The three women ranged in age from mid-20s to mid-40s when they were sterilised. All three were sterilised without their informed consent while accessing such services. Ruling in the women's favour, the High Court held that obtaining consent from women when they were in severe pain or in labour did not constitute informed consent. The Court further found that failure to obtain the three women's informed consent violated the women's rights under common law. The women will be awarded damages, although the amount is still to be decided.

# VIOLATION OF HUMAN RIGHTS

163. The issue of forced sterilisation is neither small nor new in Africa. Over 40 HIV-positive women who were allegedly sterilized against their will in Kenya are currently preparing to go to court to demand justice and possible compensation. National Gender and Equality Commission Chairperson, Winfred Lichuma who is championing the women's cause, described what happened to the women as *"atrocious an infringement of their human rights and contrary to medical ethics."* There are several similar cases pending before the courts in Zambia, South Africa, Malawi and Nambinia.<sup>282</sup>
164. In late 2011, Peru's chief prosecutor re-launched a criminal investigation into the forced sterilizations of thousands of poor and indigenous women, allegedly carried out by the government of disgraced former president Alberto Fujimori. The investigation centers on the case of *Maméríta Mestanza*, a 33-year-old mother of seven who died from complications from forced sterilization surgery. The case had been shelved in 2009 after it was decided that the statute of limitations had run out. But in November 2011 the office of Peru's attorney general, José Peláez, informed the *Inter-American Commission on Human Rights* that it was reopening the case and reclassifying the sterilizations as a crime against humanity, effectively removing the time limit for a prosecution. In one of the cases that has so far come to court, Victoria Vigo, a now 49 year old woman who was forcibly sterilised in Piura in 1996, was eventually awarded \$3,500 in compensation. During the trial the doctor argued that he had simply been obeying orders, and that the sterilization was official policy.<sup>283</sup>
165. A current case before the Inter-American Commission on Human Rights (*F.S. v. Chile*) is seeking government accountability for violations of the sexual and reproductive rights of women living with HIV. The case centres on F.S., a young woman from a rural town in Chile, was forcibly sterilised without her knowledge or consent when she was just 20 years old because she is HIV-positive. The Centre for Reproductive Rights (litigating the case with its partner Vivo Positivo) asserts that: *"the Chilean State has a responsibility to address the human rights violation that F.S. suffered, to provide reparations, and to adopt and enforce policies that guarantee women living with HIV the freedom to make reproductive health decisions without coercion."*<sup>284</sup>
166. On 12 December 2012, the International Federation for Human Rights (FIDH) and REDRESS<sup>285</sup> filed a complaint against Uzbekistan before the UN Human Rights Committee, on behalf of *Mrs Mutabar Tadjibayeva*, who was nominated for the Nobel Peace Prize in 2008 for her work as a human rights defender. Mrs Tadjibayeva was forcibly sterilised after being imprisoned for her human rights activities in Uzbekistan. In bringing the case before the UN Human Rights Committee, the litigants are hoping to *"help her receive the remedies she deserves from Uzbekistan for the grave damage and suffering caused by years of torture and ill-treatment"*.<sup>286</sup>
167. Until recently, Swedish law had required all transgender people to undergo sterilisation if they wanted to legally change their sex. In a decision on December 19 2012, the Stockholm Administrative Court of Appeal overturned the law, declaring it unconstitutional and in violation of the European Convention on Human Rights. Now, many of the estimated 500 people who have undergone forced sterilisation since the law was passed are demanding compensation.<sup>287</sup>





# REDRESS AND JUSTICE

# REDRESS AND TRANSITIONAL JUSTICE

168. Forced sterilisation of women and girls with disabilities, and the inadequacy of Australian Governments' responses to it, represent extremely grave violations of multiple human rights. The Australian Government is obliged to exercise due diligence to:

- prevent the practice of forced and coerced sterilisation from taking place;
- investigate promptly, impartially and effectively all cases of forced sterilisation of women and girls with disabilities;
- remove any time limits for filing complaints;
- prosecute and punish the perpetrators; and,
- provide adequate redress to all victims of forced or coerced sterilisation.

Meeting these obligations requires the Australian Government to take into account the marginalisation of disabled women and girls, whose rights are compromised due to deeply rooted power imbalances and structural inequalities, and to take all appropriate measures, including focused, gender-specific measures to ensure that disabled women and girls experience full and effective enjoyment of their human rights on an equal basis as others.

169. In regard to 'victims of forced or coerced sterilisation', the United Nations has made it clear that in this context:

*victims are persons who individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute gross violations of international human rights law, or serious violations of international humanitarian law.<sup>288</sup>*

170. The International Human Rights treaties to which Australia is a party, all clearly articulate the requirement for available, effective, independent and impartial remedies to be available to those whose rights have been violated under the various treaties. The Human Rights Committee has emphasised that such remedies are particularly urgent in respect of violations of the right to freedom from torture and cruel, inhuman and degrading treatment and punishment.<sup>289</sup>

# REDRESS AND TRANSITIONAL JUSTICE

171. Forced sterilisation constitutes torture.<sup>290</sup> Article 14(1) of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* specifies that States parties have a duty to ensure that victims of torture obtain redress and that they have ‘an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible’. The Special Rapporteur on Torture [and Other Cruel, Inhuman or Degrading Treatment or Punishment] has recently made it very clear that victims of torture must be provided with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation.<sup>291</sup> The *Convention on the Rights of the Child* at Article 39 also clearly articulates the importance of rehabilitation for victims of torture:

*‘States Parties shall take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment.....Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.’*

172. Therefore, redressing the harm done to women and girls with disabilities who have been sterilised in the absence of their free and informed consent requires multi-faceted responses. The right to redress and transitional justice<sup>292</sup> is articulated as an integrated right that consists of measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.<sup>293</sup>

*‘States Parties shall take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment.....Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.’*

# REDRESS AND TRANSITIONAL JUSTICE

173. Critically, in the development and implementation of any measure of redress or transitional justice for women and girls with disabilities who have been forcibly sterilised (including for eg legislation, policies, services, programs, supports, and other measures) women and girls with disabilities (including through representative organisations where they exist), must be at the forefront of all consultative and decision-making processes.

## SATISFACTION: AN OFFICIAL APOLOGY

174. Discriminatory laws, policies and practices that allowed (and continue to allow) disabled women and girls to be forcibly sterilised have left, and will leave, legacies of personal pain and distress that will continue to reverberate long into the future. First and foremost, redress demands that Governments acknowledge the pervasive practice of forced and coerced sterilisation of disabled women and girls (through a full and public disclosure of the truth) - and issue an official apology to those affected (including public acknowledgement of the facts and acceptance of responsibility).<sup>294</sup>
175. In 2000, the Canadian Government issued a national apology to the 703 people who were forcibly sterilised under that province's Sexual Sterilisation Act.<sup>295</sup> In 2002, the State of North Carolina issued a formal apology to the estimated 7,600 people forcibly sterilised in that State between 1929 and 1974.<sup>296</sup>

# REDRESS AND TRANSITIONAL JUSTICE

## GUARANTEES OF NON-REPETITION – LAW REFORM

176. The monitoring committees of the International Human Rights Treaties have made it clear that legislative reform is a critical component of redress for women and girls who have been sterilised in the absence of their free and informed consent. Legislative reform in this context includes, but is not restricted to:
- the enactment of national legislation prohibiting, except where there is a serious threat to life, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent. Such legislation must criminalise the removal of a child or adult with a disability from the Country with the intention of having a forced sterilisation procedure performed;<sup>297</sup>
  - the enactment of national legislation that replaces regimes of substitute decision making for people with disabilities with supported decision-making which respects the persons autonomy, will and preferences;<sup>298</sup>
  - repealing any laws, policies and practices which permit guardianship and trusteeship for adults (and replacing regimes of substituted decision-making by supported decision making).<sup>299</sup>
  - ensuring that the requirement for full and informed consent in all interventions and treatments concerning people with disabilities is enshrined in relevant legal frameworks at national and state/territory levels;<sup>300</sup>
  - ensuring that criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent is clarified in the law, and that no distinction between persons with or without disabilities is made; and,<sup>301</sup>
  - ensuring that any law or policy which restricts in any way, a disabled woman's [and girls] right to full enjoyment of her sexual and reproductive health rights and freedoms, is amended as a matter of urgency. This includes laws, policies or programs that deny disabled women the right to found a family (including for eg: policies that deny access to assisted reproduction, adoption, surrogacy) and to maintain a family (eg: policies that enable removal of babies and children from parents with disabilities on the basis of parental disability).<sup>302</sup>

# REDRESS AND TRANSITIONAL JUSTICE

## COMPENSATION

177. Compensation is an important component of redress and transitional justice for women and girls who have been sterilised in the absence of their free and informed consent. Whilst it is recognised that financial compensation can never make up for the immense harm caused to the women and girls affected, it is a critical element in States accountability for those harms. Financial compensation has been awarded in a number of cases where girls and women with disabilities were sterilised in the absence of their free and informed consent.<sup>303</sup>
178. In October 1989, Leilani Muir filed a lawsuit against the Alberta government for wrongfully classifying her as “feeble-minded,” which led to her forced sterilisation. In 1995, the provincial Court of Queen’s Bench ruled in Muir’s favour, and awarded her \$740,000 in damages, and another \$230,000 in legal costs. Leilani Muir’s lawsuit was the first one to ever successfully sue the government for forced sterilisation.<sup>304</sup>
179. In 2000, in a joint action suit that arose from the Leilani Muir case, the Alberta Government financially compensated 703 other defendants who were forcibly sterilised under that province’s Sexual Sterilisation Act.<sup>305</sup>
180. In 1999, the Swedish Government finally compensated approximately 200 citizens - mostly female - who were forcibly sterilised between 1935 and 1975.<sup>306</sup>
181. In North Carolina, Governor Beverly Perdue established the *North Carolina Justice for Sterilization Victims Foundation*<sup>307</sup> in 2010 to provide justice and compensate victims who were forcibly sterilised by the State of North Carolina, under the former North Carolina Eugenics Board program. From 1929 until 1974, an estimated 7,600 North Carolinians, women and men, many of whom were disabled, were forcibly sterilised under the Program. In March 2011, Governor Perdue established a five-member Task Force<sup>308</sup> to recommend possible methods or forms of compensation to those affected. The Task Force’s Final Report,<sup>309</sup> released in 2012, recommended a package of compensation that:

*“provides a lump-sum financial payment [\$50,000] and mental health services to living victims. The package also provides for the expansion of the N.C. Justice for Sterilization Victims Foundation and public education to serve as a deterrent against any future abuse of power by the government of North Carolina.”*



# REDRESS AND TRANSITIONAL JUSTICE

## REHABILITATION & RECOVERY

182. Women and girls with disabilities who have been forcibly sterilised are entitled to a full range of rehabilitation and recovery measures. In this context, 'rehabilitation and recovery' must be understood holistically, recognising that measures would need to include for example: psychological, physical, health and medical care; legal and social services; economic empowerment; housing; education and employment; transport; access to justice; as well as the elements of political and moral rehabilitation.<sup>310</sup> Importantly, rehabilitation and recovery measures should be tailored to each individual's needs and particular situation and ensure active participation of the survivors and their allies. Moreover, as highlighted by Somasundaram:<sup>311</sup>

*"it is necessary to consider the effects of torture and other violations on families, communities and society (collective trauma). Rehabilitation and recovery programmes should promote individual, family and social healing, recovery and reintegration."*

183. Rehabilitation and recovery measures for women and girls with disabilities who have been forcibly sterilised, must also be understood as not merely a form of reparation, but also as an explicit right under Article 26 of the *Convention on the Rights of Persons With Disabilities* (CRPD).<sup>312</sup>

*"it is necessary to consider the effects of torture and other violations on families, communities and society (collective trauma). Rehabilitation and recovery programmes should promote individual, family and social healing, recovery and reintegration."*

# REDRESS AND TRANSITIONAL JUSTICE

## PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF WOMEN AND GIRLS WITH DISABILITIES

184. Reproductive rights and freedoms rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes the right to make decisions regarding reproduction free of discrimination, coercion and violence.<sup>313</sup> For women and girls with disabilities, reproductive rights and freedoms encompass for example: the right to bodily integrity and bodily autonomy, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a normal way, the right to sex education, to informed consent regarding birth control, to terminate a pregnancy, to choose to be a parent, to access reproductive information, resources, medical care, services, and support; the right to experience and express their sexuality; the right to experience love, intimacy, sexual identity; the right to privacy, and the right to be free from interference.<sup>314</sup>
185. Yet, as highlighted earlier in this Submission, no group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights and freedoms, as women and girls with disabilities.<sup>315</sup> The practice of forced sterilisation is itself part of a broader pattern of denial of human and reproductive rights of Australian disabled women and girls which also includes systematic exclusion from appropriate reproductive health care and sexual health screening, forced contraception and/or limited contraceptive choices, a focus on menstrual suppression, poorly managed pregnancy and birth, selective or coerced abortion and the denial of rights to parenting.<sup>316</sup> These practices are framed within traditional social attitudes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.<sup>317</sup>
186. Whilst there are exceptions,<sup>318</sup> there appear to be very few specific, targeted initiatives for women and girls with disabilities in Australia regarding a rights based approach to sexual and reproductive health. Where they exist, the majority of initiatives focusing on disability, sexuality and reproductive rights – are not gendered, focus largely on people with intellectual disabilities, tend to overlook the sexual and reproductive health needs of other women and girls with disabilities, and appear to be primarily targeted at service providers and/or parents and carers.<sup>319</sup>
187. It is outside the scope of this Submission to address the wide-ranging and extensive raft of actions required to promoting the sexual and reproductive health rights of women and girls with disabilities. It is however, clearly an area that requires urgent and intensive attention, in consultation with women and girls with disabilities and their allies.



# CONCLUSION

# CONCLUSION

This Submission from WWDA to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia, establishes beyond doubt, that forced and coerced sterilisation of women and girls with disabilities is a form of torture – a heinous, inhuman practice which violates multiple human rights, and clearly breaches every international human rights treaty to which Australia is a party.

For decades, uninterested and apathetic Australian Governments have been complicit in allowing this form of torture to be perpetrated against women and girls with disabilities, indifferent to the devastating and life-long effects it has on some of our countries most marginalised and excluded citizens.

This Submission has provided an extensive amount of evidence which warrants the Australian Government stop procrastinating on this issue, and act immediately and decisively to put an end to the barbaric practice that is forced sterilisation. In so doing, it must acknowledge and take full responsibility for the wrongs that have been done to those affected, including formally apologising for the discriminatory actions, policies, culture and attitudes that result in forced and coerced sterilisation and that acknowledges, on behalf of the nation, the immense harm done to those who have been forcibly sterilised and experienced other violations of their reproductive rights.

In addition, the Australian Government must do everything in its power to not only enable redress and justice for all those affected by forced and coerced sterilisation, but also take all measures necessary, including focused, gender-specific measures, to ensure that disabled women and girls experience full and effective enjoyment of all their human rights on an equal basis as others.





# FOOTNOTES

# FOOTNOTES

- <sup>1</sup> For more detailed information on Women With Disabilities Australia (WWDA), go to: <http://www.wwda.org.au>
- <sup>2</sup> See WWDA's *Strategic Plan 2010 – 2015* at: <http://www.wwda.org.au/stratplan.htm>
- <sup>3</sup> See: *On The Record – A Report on the 1990 STAR Conference on Sterilisation: 'My Body, My Mind, My Choice'*. Edited by Fiona Strahan, Co-Editor Lois Brudenell. Available at: <http://www.wwda.org.au/record.htm> NB: The graphic used above is taken from the *On The Record* Report.
- <sup>4</sup> Commonwealth of Australia (2009) *A Stronger, Fairer Australia: National Statement on Social Inclusion*. Department of the Prime Minister and Cabinet, Canberra; McClelland, R. in Commonwealth of Australia (2010) *Australia's Human Rights Framework*, Attorney-General's Department, Canberra; Australian Government *Australian Values Statement*, Department of Immigration & Citizenship, available online at: <http://www.immi.gov.au/living-in-australia/values/statement/long/> Commonwealth of Australia (2007) *Life in Australia*; Department of Immigration & Citizenship, available online at: [http://www.immi.gov.au/living-in-australia/values/book/english/lia\\_english\\_full.pdf](http://www.immi.gov.au/living-in-australia/values/book/english/lia_english_full.pdf)
- <sup>5</sup> Roos, P. (1975) Psychological Impact of Sterilization on the Individual; *Law and Psychology Review*, Issue 45, pp.45-54.
- <sup>6</sup> 'Forced/involuntary sterilisation' refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure - including instances in which sterilisation has been authorised by a third party, without that individual's consent. Coerced sterilisation occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent. 'Non-therapeutic sterilisation' has been defined as sterilisation for a purpose other than to 'treat some malfunction or disease': *Secretary, Department of Health and Community Services v JWB and SMB*, 1992, 175 CLR 218; 106 ALR 385. For further discussion, see for example: Méndez, Juan. E, (2013) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN General Assembly; UN.Doc A/HRC/22/53; Dowse, L. & Frohmader, C. (2001) *Moving Forward: Sterilisation and Reproductive Health of Women and Girls with Disabilities*, A Report on the National Project conducted by Women with Disabilities Australia (WWDA), Canberra. See also: Brady, S., Briton, J., & Grover, S. (2001) *The Sterilisation of Girls and Young Women in Australia: Issues and Progress*. A report commissioned by the Federal Sex Discrimination Commissioner and the Disability Discrimination Commissioner; Human Rights and Equal Opportunity Commission, Sydney, Australia. Available at: [www.wwda.org.au/brady2.htm](http://www.wwda.org.au/brady2.htm); See also: WWDA, Human Rights Watch (HRW), Open Society Foundations, and the International Disability Alliance (IDA) (2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper*. Available at: [http://www.wwda.org.au/Sterilization\\_Disability\\_Briefing\\_Paper\\_October2011.pdf](http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf)
- <sup>7</sup> Centre for Reproductive Rights, European Disability Forum, InterRights, International Disability Alliance and the Mental Disability Advocacy Centre (2011) *Written Comments Submitted in the European Court of Human Rights: Joelle Gauer and Others [Applicant] Against France [Respondent]*, 16 August 2011. See also: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>8</sup> The United Nations Special Rapporteurs on Violence Against Women have asserted that forced sterilisation is a method of medical control of a woman's fertility. It violates a woman's physical integrity and security and constitutes violence against women. See: Manjoo, Rashida (2012) *Report of the Special Rapporteur on violence against women, its causes and consequences*; UN General Assembly; UN Doc. A/67/227; and also Radhika Coomaraswamy (1999), *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences: Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, (55th Sess.), E/CN.4/1999/68/Add.4 (1999), [para. 51].
- <sup>9</sup> Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*; UN General Assembly, UN Doc. A/HRC/7/3; Committee on the Rights of the Child (2011) *General Comment No. 13: Article 19: The right of the child to freedom from all forms of violence*; UN Doc. CRC/C/GC/13.
- <sup>10</sup> International NGO Council on Violence against Children (October 2012) *Violating Children's Rights: Harmful practices based on tradition, culture, religion or superstition*. Accessed online October 2012 at: [http://www.crin.org/docs/InCo\\_Report\\_15Oct.pdf](http://www.crin.org/docs/InCo_Report_15Oct.pdf)
- <sup>11</sup> A State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres. As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors. See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>12</sup> See: Méndez, Juan. E, (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit.,



# FOOTNOTES

- <sup>13</sup> “*Jus cogens*, the literal meaning of which is “compelling law,” is the technical term given to those norms of general international law that are argued as hierarchically superior. These are a set of rules, which are peremptory in nature and from which no derogation is allowed under any circumstances. The doctrine of international *jus cogens* was developed under a strong influence of natural law concepts, which maintain that states cannot be absolutely free in establishing their contractual relations. States were obliged to respect certain fundamental principles deeply rooted in the international community. The power of a state to make treaties is subdued when it confronts a super-customary norm of *jus cogens*. In other words, *jus cogens* are rules, which correspond to the fundamental norm of international public policy and in which cannot be altered unless a subsequent norm of the same standard is established. This means that the position of the rules of *jus cogens* is hierarchically superior compared to other ordinary rules of international law.” Taken from: Hossain, K. (2005) The Concept of *Jus Cogens* and the Obligation Under the U.N. Charter. *Santa Clara Journal of International Law*, Vol. 3, pp.72-98. As detailed in *Prosecutor v. Furundzija* “The *jus cogens* nature of the prohibition against torture articulates the notion that the prohibition has now become one of the most fundamental standards of the international community. States are obliged not only to prohibit and punish torture, but also prevent its occurrence and consequently, are bound to put in place all those measures that may pre-empt the perpetration of torture. See: International human rights law not only prohibits torture (as well as any inhuman and degrading treatment) but also prohibits (a) the failure to adopt the national measures necessary for implementing the prohibition and (b) the maintenance in force or passage of laws which are contrary to the prohibition. See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor v. Furundzija*, Case IT-95-17/1-T; Judgement, 10 December 1998.
- <sup>14</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit., See also: Sifris, R. (2010) Conceptualising involuntary Sterilisation as ‘Severe Pain or Suffering for the Purposes of Torture Discourse. *Netherlands Quarterly of Human Rights*, Vol.28/4, pp.523-547.
- <sup>15</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.,
- <sup>16</sup> Sifris, R. (2010) Op Cit.
- <sup>17</sup> Ibid.
- <sup>18</sup> Centre for Reproductive Rights et al, Op Cit., Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit.,
- <sup>19</sup> Ibid.
- <sup>20</sup> Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention; *Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).
- <sup>21</sup> Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.
- <sup>22</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>23</sup> Dowse, L. (2004) ‘Moving Forward or Losing Ground? The Sterilisation of Women and Girls with Disabilities in Australia’. Paper presented to Disabled Peoples’ International (DPI) World Summit, Winnipeg, September 8–10, 2004. Available online at: <http://www.wvda.org.au/steril3.htm>; Steele, L. (2008) Making sense of the Family Court’s decisions on the non-therapeutic sterilisation of girls with intellectual disability; *Australian Journal of Family Law*, Vol.22, No.1.; Prilleltensky, O. (2003) A Ramp to Motherhood: The Experiences of Mothers with Physical Disabilities. *Sexuality and Disability*, Vol. 21, No. 1, pp. 21–47.
- <sup>24</sup> An extensive amount of this work is available on WVDA’s website. See: <http://www.wvda.org.au/sterilise.htm>
- <sup>25</sup> *Universal Declaration of Human Rights*; proclaimed by the United Nations General Assembly on 10 December 1948 General Assembly resolution 217 A (III).
- <sup>26</sup> Such a Task Force must include women with disabilities in its membership, and be chaired by a woman with a disability.
- <sup>27</sup> See for eg: The Nairobi Declaration on Women’s and Girls’ Right to a Remedy and Reparation. Available at: <http://www.redress.org/downloads/publications/Nairobi%20Principles%20on%20Women%20and%20Girls.pdf>
- <sup>28</sup> This includes laws, policies or programs that deny disabled women the right to found a family (including for eg: policies that deny access to assisted reproduction, adoption, surrogacy) and to maintain a family (eg: policies that enable removal of babies and children from parents with disabilities on the basis of parental disability).
- <sup>29</sup> This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child’s extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/>
- <sup>30</sup> Through the Looking Glass (TLG) is a national disability community based non-profit organization providing research, training, and services for families in which a child, parent or grandparent has a disability or medical issue. TLG includes the *National Center for Parents with Disabilities and their Families* which provides an extensive range of services and support for parents with disabilities. TLG is nationally recognised for designing and fabricating baby care equipment for parents and other caregivers with disabilities, as well as studying the impact of this equipment on parenting. An adaptive equipment hire service is just one of the many services available. See: <http://www.lookingglass.org/>

# FOOTNOTES

- <sup>31</sup> For more information see: <http://www.ahpra.gov.au>
- <sup>32</sup> Grover, A., (2009) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. UN General Assembly, UN Doc. A/64/272.
- <sup>33</sup> Sterilisation which is performed in an emergency situation for life-saving purposes, like any life-saving procedure, is not considered to be forced sterilisation. See: Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>34</sup> Centre for Reproductive Rights et al (2011) Op Cit. See also: Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>35</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>36</sup> Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, & International Disability Alliance (IDA)(2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper* (November). Available online at: [http://www.wwda.org.au/Sterilization\\_Disability\\_Briefing\\_Paper\\_October2011.pdf](http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf) See also: Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>37</sup> Brady, S. (2001) *The sterilisation of girls and young women with intellectual disabilities in Australia: An audit of Family Court and Guardianship Tribunal cases between 1992-1998*. Available online at: [www.wwda.org.au/brady2001.htm](http://www.wwda.org.au/brady2001.htm)
- <sup>38</sup> See: Commonwealth of Australia (1994) *Sterilisation and Other Medical Procedures on Children*. A report to the Attorney-General prepared by the Family Law Council. Available at: <http://www.ag.gov.au/Documents/sterilisation-and-other-medical-procedures.htm> See also: See also: Brady, S., Briton, J., & Grover, S. (2001) Op Cit.
- <sup>39</sup> Grover, A. (2011) *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. United Nations General Assembly; UN Doc. A/66/254.
- <sup>40</sup> Frohmader, C. & Meekosha, H. (2012) Recognition, respect and rights: Women with disabilities in a globalised world. In *Disability and Social Theory*, Edited by Dan Goodley, Bill Hughes and Lennard Davis, London: Palgrave Macmillan.
- <sup>41</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Sterilise Please at 10:10 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>42</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Kika at 9:47 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>43</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by soap box dude at 11:13 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>44</sup> Morse, F. (2013) Colin Brewer Cornwall Councillor Says 'Disabled Children Should Be Put Down'. *The Huffington Post*, 27/02/2013. Accessed online February 2013 at: [http://www.huffingtonpost.co.uk/2013/02/27/cornwall-councillor-colin-brewer-disabled-children-put-down\\_n\\_2771826.html?utm\\_hp\\_ref=uk](http://www.huffingtonpost.co.uk/2013/02/27/cornwall-councillor-colin-brewer-disabled-children-put-down_n_2771826.html?utm_hp_ref=uk)
- <sup>45</sup> Cooke, E., et al, cited in Dowse, L. & Frohmader, C. (2001) Op Cit.
- <sup>46</sup> Goldhar, J. cited in Dowse, L. & Frohmader, C. (2001) Op Cit.
- <sup>47</sup> Department of Health and Community Services v JWB and SMB (Marion's Case) [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992). At: [http://www.austlii.edu.au/au/cases/cth/high\\_ct/175clr218.html](http://www.austlii.edu.au/au/cases/cth/high_ct/175clr218.html)
- <sup>48</sup> 'Non-therapeutic sterilisation' is sterilisation for a purpose other than to 'treat some malfunction or disease': Secretary, Department of Health and Community Services v JWB and SMB, 1992, 175 CLR 218; 106 ALR 385.
- <sup>49</sup> Dowse, L. (2004) Op Cit.
- <sup>50</sup> Jones, M. and Basser Marks, L. (2000) Valuing People through Law: Whatever Happened to Marion? In M. Jones and L. A. Basser Marks (eds) *Explorations on Law and Disability in Australia*. Sydney, Federation Press.
- <sup>51</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>52</sup> Standing Committee of Attorneys-General (SCAG) (2004) *Issues Paper on the Non-Therapeutic Sterilisation of Minors with a Decision-Making Disability*. Available online at: [www.wwda.org.au/scagpap1.htm](http://www.wwda.org.au/scagpap1.htm)
- <sup>53</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>54</sup> Transcript from 2003 Four Corners (ABC TV) Documentary 'Walk in Our Shoes'. Available online at: <http://www.wwda.org.au/4corners.htm>
- <sup>55</sup> The Standing Committee of Attorneys-General (SCAG) was the national ministerial council made up of the Australian Attorney-General and the State and Territory Attorneys-General. SCAG provides a forum for Attorneys-General to discuss and progress matters of mutual interest. It seeks to achieve uniform or harmonised action within the portfolio responsibilities of its members. In 2011 the SCAG was re-named the Standing Council on Law and Justice (SCLJ).
- <sup>56</sup> Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Draft 17: Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*. Available at: [www.wwda.org.au/sterbill06.pdf](http://www.wwda.org.au/sterbill06.pdf)
- <sup>57</sup> Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Issues Paper on the Sterilisation of Intellectually Disabled Minors*. Available at: [www.wwda.org.au/scagpap2.htm](http://www.wwda.org.au/scagpap2.htm)

# FOOTNOTES

- <sup>58</sup> Standing Committee of Attorneys-General (SCAG) Working Group (2006) *Draft 17: Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*. Available at: [www.wwda.org.au/sterbill06.pdf](http://www.wwda.org.au/sterbill06.pdf) A number of Submissions provided to the SCAG Working Party in response to the Draft *Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006*, are available on WWDA's website at: <http://www.wwda.org.au/steriladv07.htm>
- <sup>59</sup> Standing Committee of Attorneys-General (SCAG) *Communique* 28 March 2008.
- <sup>60</sup> Ibid.
- <sup>61</sup> Correspondence to WWDA from WA Attorney-General Christian Porter MLA, 18 June 2009.
- <sup>62</sup> Australian Government (2009) *Response to the United Nations (UNESCAP) Questionnaire for Governments on Implementation of the Beijing Declaration and Platform for Action (BPFA) and the outcomes of the twenty-third special session of the General Assembly (2000)*. Accessed online February 2010 at: [www.unescap.org/ESID/GAD/Issues/Beijing+15/Responds\\_to\\_Questionnaire/Australia.pdf](http://www.unescap.org/ESID/GAD/Issues/Beijing+15/Responds_to_Questionnaire/Australia.pdf) [See page 14].
- <sup>63</sup> Australian Government (2006) *Sterilisation of Women and Young Girls with an Intellectual Disability - Report to the Senate*. Tabled by the Minister for Family and Community Services and the Minister Assisting the Prime Minister on the Status of Women, December 6, 2000. Available online at: [www.wwda.org.au/senate.htm](http://www.wwda.org.au/senate.htm)
- <sup>64</sup> Hon Robert McClelland (Attorney-General) Correspondence to Women With Disabilities Australia (WWDA), 27 August, 2009.
- <sup>65</sup> Brady, S. and Grover, S. (1997) *The Sterilisation of Girls and Young Women in Australia - A legal, medical and social context*. Report commissioned by the Federal Disability Discrimination Commissioner for the Human Rights and Equal Opportunity Commission, December 1997. Available online at: <http://www.wwda.org.au/brady.htm>
- <sup>66</sup> Australian Government (2009) *Response to the United Nations (UNESCAP) Op Cit*.
- <sup>67</sup> Ibid.
- <sup>68</sup> Correspondence from WWDA to Hon Robert McClelland, Attorney General, February 24, 2010.
- <sup>69</sup> See for example: Re: Angela [2010] FamCA 98 (16 February 2010); HGL (No 2) [2011] QCATA 259 (19 September 2011); Gardner, J. (2003) cited in Transcript from 2003 Four Corners (ABC TV) Op Cit; Nicholson, Justice Alastair (2003) cited in Transcript from 2003 Four Corners (ABC TV) Op Cit; Australian Human Rights Commission (2012) *The Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, Australian Human Rights Commission Submission to the Senate Community Affairs References Committee; , also: Shepherd, T. (2013) South Australian disability advocates term forced hysterectomies as torture. *The Advertiser*, February 28, 2013. Accessed online February 2013 at: <http://www.adelaidenow.com.au/news/south-australia/south-australian-disability-advocates-term-forced-hysterectomies-as-torture/story-e6frea83-1226587191569>
- <sup>70</sup> Transcript from 2003 Four Corners (ABC TV) Op Cit.
- <sup>71</sup> Transcript from 2003 Four Corners (ABC TV) Op Cit.
- <sup>72</sup> Ibid.
- <sup>73</sup> Australian Government (2008) *Fourth Report under the Convention on the Rights of the Child: Australia*, October 2008, 159, p31. Accessed online August 2009 at: [http://www.ag.gov.au/www/agd/agd.nsf/Page/Humanrightsandantidiscrimination\\_ReportsundertheConventionontheRightsOftheChild](http://www.ag.gov.au/www/agd/agd.nsf/Page/Humanrightsandantidiscrimination_ReportsundertheConventionontheRightsOftheChild)
- <sup>74</sup> WWDA's formal complaint is available online at: [http://wwda.org.au/WWDA\\_Submission\\_SR2011.pdf](http://wwda.org.au/WWDA_Submission_SR2011.pdf)
- <sup>75</sup> Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and Rashida Manjoo, Special Rapporteur on violence against women, its causes and consequences. See Appendix 2.
- <sup>76</sup> Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention; *Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).
- <sup>77</sup> Committee on the Rights of the Child; UN Doc. CRC/C/AUS/CO/4.
- <sup>78</sup> Committee on the Rights of the Child; UN Doc. CRC/C/AUS/4.
- <sup>79</sup> The Universal Periodic Review (UPR) is a process undertaken by the United Nations and involves the review of the human rights records of the 192 Member States once every four years. The UPR provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations. The ultimate aim of the Review is to improve the human rights situation in all countries and address human rights violations wherever they occur. For more information see: <http://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>
- <sup>80</sup> UN General Assembly Human Rights Council (2011) UN Doc A/HRC/17/10, Op Cit.

# FOOTNOTES

- <sup>81</sup> On 10 December 2012, International Human Rights Day, the Australian Government released its National Human Rights Action Plan. In releasing the Plan, the then Federal Attorney General, Hon Nicola Roxon MP, stated that: *'This action plan explains in detail how Australia will implement the recommendations accepted during its Universal Periodic Review at the United Nations in 2011.'* See for eg: Commonwealth of Australia (2012) *Australia's National Human Rights Action Plan 2012*. Accessed online 10 December 2012 at: <http://www.ag.gov.au/Humanrightsandantidiscrimination/Australiahumanrightsframework/Pages/NationalHumanRightsActionPlan.aspx> See also: The Hon Nicola Roxon MP, Attorney-General & Minister for Emergency Management, Media Release *'National Human Rights Action Plan Released'*, 10 December 2012.
- <sup>82</sup> Committee on the Elimination of Discrimination against Women (2010) UN Doc. CEDAW/C/AUS/CO/7, Op Cit.
- <sup>83</sup> Australian Government (2012) *'Responses by Australia to the recommendations contained in the concluding observations of the Committee following the examination of the combined sixth and seventh periodic report of Australia on 20 July 2010.'* Accessed February 2013 at: <http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW.C.AUL.CO.7.Add.1.pdf>
- <sup>84</sup> The CEDAW Committee made two specific recommendations for actions on violence against women and Aboriginal and Torres Strait Islander women, in its Concluding Observations on Australia and requested an update on progress at the 2-year mark, prior to a full review in 2014. The Australian Government was required to report back to the CEDAW committee on its progress on these two areas by July 2012.
- <sup>85</sup> Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.
- <sup>86</sup> UN Convention on the Rights of the Child (CRC)(2004) *Consideration of Reports Submitted By States Parties Under Article 44 of the Convention; Second and third periodic reports of States parties due in 1998 and 2003:Australia*; 29 December 2004; CRC/C/129/Add.4.
- <sup>87</sup> UN Committee on the Rights of the Child, UN Doc. CRC/C/15/Add.268, Op Cit.
- <sup>88</sup> CRC General Comment No.9 [at para.60] states: *'The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.'* See: Committee on the Rights of the Child (CRC), *General Comment No. 9 (2006): The rights of children with disabilities*, 27 February 2007, UN Doc.CRC/C/GC/9.
- <sup>89</sup> Since Australia was last reviewed in 2009, the Human Rights Committee has developed a new optional process for the review of states, known as the List of Issues Prior to Reporting (LOIPR). The Human Rights Committee develops a LOIPR on the basis of previous Concluding Observations and information provided by the Office of the High Commissioner on Human Rights (OHCHR), the Universal Periodic Review (UPR), the UN Special Procedures, NGOs and National Human Rights Institutions. The LOIPR on Australia was adopted by the Human Rights Committee at its 106th session in late 2012.
- <sup>90</sup> Human Rights Committee, International Covenant on Civil and Political Rights; *List of issues prior to the submission of the sixth periodic report of Australia* (CCPR/C/AUS/6), adopted by the Committee at its 106th session (15 October–2 November 2012); UN Doc No. CCPR/C/AUS/Q/6; 9 November 2012.
- <sup>91</sup> See: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx>
- <sup>92</sup> The Australian Civil Society CRPD Shadow Report is available at: <http://www.disabilityrightsnow.org.au/node/15>
- <sup>93</sup> See Disability Council International's 2013 Independent Review of Australia's initial state party report (CRPD/C/AUS/1) available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx>; See also Australian Civil Society CRPD Shadow Report, also available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session9.aspx>
- <sup>94</sup> FIGO (International Federation of Gynecology and Obstetrics), *Female Contraceptive Sterilization*. Available at: <http://www.wwda.org.au/FIGOGuidelines2011.pdf> See also Appendix 1.
- <sup>95</sup> Shepherd, T. (2013) South Australian disability advocates term forced hysterectomies as torture. The Advertiser, February 28, 2013. Accessed online February 2013 at: <http://www.adelaidenow.com.au/news/south-australia/south-australian-disability-advocates-term-forced-hysterectomies-as-torture/story-e6frea83-1226587191569>
- <sup>96</sup> World Medical Association (WMA) in conjunction with the International Federation of Health and Human Rights Organizations (IFHHRO) (2011) *Global Bodies call for end to Forced Sterilisation*: Press Release, 5 September 2011. Available at: <http://www.wwda.org.au/sterilWMA2011.htm>
- <sup>97</sup> The International NGO Council on Violence Against Children was formed in 2007 to support strong and effective follow-up to the UN Study on Violence against Children. See: <http://www.crin.org/violence/NGOs/>
- <sup>98</sup> International NGO Council on Violence against Children (October 2012) *Violating Children's Rights: Harmful practices based on tradition, culture, religion or superstition*. Available online at: [http://www.crin.org/docs/InCo\\_Report\\_15Oct.pdf](http://www.crin.org/docs/InCo_Report_15Oct.pdf)
- <sup>99</sup> In recent months, WHO led a broad and inclusive consultation process which included: 12 September 2012: a meeting with governments and civil society during the Conference of States Parties in New York. After the consultation, participants were requested to comment on the Statement and twenty responses were received; 27 October 2012: a consultation with people with intellectual disabilities at the Global Forum of Inclusion International in Washington DC; Further consultation with people with intellectual disabilities on a plain language version of the Statement; 15-16 October 2012: an expert consultation held in Geneva to discuss the Statement in detail. As a result of these inputs, the proposed Statement has been strengthened. Other UN agencies are now reviewing the Statement and assessing how they may be able to support its implementation. See: [http://www.who.int/disabilities/media/news/2012/14\\_11/en/index.html](http://www.who.int/disabilities/media/news/2012/14_11/en/index.html)
- <sup>100</sup> The *Global Stop Torture in Health Care Campaign* is an alliance of international health and human rights organisations working together to put an end to the abuse of individuals in health settings. It is co-ordinated by the Open Society Foundations. See: <http://www.facebook.com/StopTortureInHealthCare>

# FOOTNOTES

- <sup>101</sup> See: <http://www.facebook.com/StopTortureInHealthCare>
- <sup>102</sup> Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, & International Disability Alliance (IDA) (2011) Op Cit. See also: Brady, S., Briton, J., & Grover, S. (2001), Op Cit.
- <sup>103</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>104</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Comment 70 of 162 posted at 10:14 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>105</sup> Online response to The Advertiser article *'The International Day of Disability sheds light on the murky world of disability'*; Dec 2, 2012. Response posted by Sarah at 9:53 AM December 03, 2012. Accessed December 2012 at: <http://www.adelaidenow.com.au/news/opinion/the-international-day-of-disability-sheds-light-on-the-murky-world-of-disability-writes-ali-carle/story-e6frea3-1226528397995>
- <sup>106</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Nicki of Brisbane at 8:43 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>107</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by James at 3:52 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>108</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Ben of Sydney at 12:13 PM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>109</sup> Online response to News article *'Mother tells senate inquiry that sterilising her disabled daughter was a blessing'*. Response posted by Jo at 7:11 PM December 03, 2012. Accessed online December 2012 at: <http://www.news.com.au/lifestyle/parenting/sterilisation-was-a-blessing-mother/story-fnet085v-1226529050764>
- <sup>110</sup> Online response to The Advertiser News article *'The International Day of Disability sheds light on the murky world of disability'*. Response posted by Earl Grey at 10:20 PM December 02, 2012. Accessed online December 2012 at: <http://www.adelaidenow.com.au/news/opinion/the-international-day-of-disability-sheds-light-on-the-murky-world-of-disability-writes-ali-carle/story-e6frea3-1226528397995>
- <sup>111</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by 'mother of one in WA' at 4:01 PM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>112</sup> Brady, S. and Grover, S. (1997) Op Cit.
- <sup>113</sup> Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.
- <sup>114</sup> Frohmader, C. and Meekosha, H. (2012) Op Cit.
- <sup>115</sup> Re: Angela [2010] FamCA 98 (16 February 2010)
- <sup>116</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>117</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>118</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>119</sup> HGL (No 2) [2011] QCATA 259 (19 September 2011)
- <sup>120</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>121</sup> Re M (An Infant) [1992] FamCA 19 (3 April 1992)
- <sup>122</sup> Re Elizabeth Suit [1989] FamCA 20 (3 May 1989)
- <sup>123</sup> Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993)
- <sup>124</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>125</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>126</sup> XTV [2012] NSWGT 5 (6 February 2012)
- <sup>127</sup> Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit.
- <sup>128</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>129</sup> Dowse, L. (2004) Op Cit. See also: Brady, S. & Grover, S. (1997) Op Cit.; Jones M. & Basser Marks L. (1997) *Female and Disabled: A Human Rights Perspective on Law and Medicine* in K. Petersen (ed) *Intersections: Women on Law, Medicine and Technology* Aldershot, Dartmouth: 49-71.
- <sup>130</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>131</sup> Brady, S. and Grover, S. (1997) Op Cit.



# FOOTNOTES

- <sup>132</sup> Ibid. See also: Steele, L. (2008) Op Cit.; Brady, S., Briton, J. and Grover, S. (2001) Op Cit.
- <sup>133</sup> Women With Disabilities Australia (WWDA) (2007) *Policy & Position Paper: The Development of Legislation to Authorise Procedures for the Sterilisation of Children with Intellectual Disabilities*. Available at: <http://www.wwda.org.au/polpapster07.htm> See also: New South Wales Council for Intellectual Disability (2006) *Submission on the Draft Model Bill to regulate the sterilisation of children with an intellectual disability*. Available online at: <http://www.wwda.org.au/sternswcid06.htm>; Intellectual Disability Rights Service (IDRS) (2006) *Submission on the Draft Model Bill to regulate the sterilisation of children with an intellectual disability*. Available online at: <http://www.wwda.org.au/sterids06.htm>
- <sup>134</sup> This happens in two main ways: a) the child is removed by child protection authorities and placed in foster or kinship care; and b) a Court, under the *Family Law Act*, may order that a child be raised by the other parent who does not have a disability or by members of the child's extended family. See: Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/>
- <sup>135</sup> Victorian Office of the Public Advocate (OPA) (2012) *OPA Position Statement: The removal of children from their parent with a disability*. <http://www.publicadvocate.vic.gov.au/research/302/>
- <sup>136</sup> Cited in: Cocks, K. (2012) *Human Rights of Parents with Intellectual Disability*. Speech by Queensland Anti-Discrimination Commissioner, to the Bold Network and QUT Symposium *Realising the Dreams and Hopes of Parents with Intellectual Disability* held at QUT Gardens Point, Brisbane City on Monday, 19 November 2012. Accessed online February 2013 at: [http://www.adcq.qld.gov.au/Speeches/Parents\\_with-Intellectual\\_Disability.html](http://www.adcq.qld.gov.au/Speeches/Parents_with-Intellectual_Disability.html)
- <sup>137</sup> In Women With Disabilities Australia (WWDA) (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*. WWDA, Rosny Park, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm>
- <sup>138</sup> Ibid.
- <sup>139</sup> Ibid.
- <sup>140</sup> For example, in 2007, the Victorian Law Reform Commission (VLRC) released its final report on Assisted Reproductive Technology (ART) and adoption. The VLRC had been commissioned by the Victorian Government to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* [Vic] and the *Adoption Act 1984* [Vic] to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption (VLRC 2007). In relation to access to assisted reproductive technology, the VLRC decided "not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child" See: Victorian Law Reform Commission (VLRC) (2007) *Assisted Reproductive Technology & Adoption: Final Report*. Victorian Law Reform Commission, Melbourne, Victoria.
- <sup>141</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>142</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>143</sup> Re: Angela [2010] FamCA 98 (16 February 2010)
- <sup>144</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>145</sup> Re A Teenager [1988] FamCA 17 (15 November 1988)
- <sup>146</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>147</sup> See for example: Sheerin, F. (1998) Parents with learning disabilities: a review of the literature. *Journal of Advanced Nursing*; Vol.28, No.1, pp.126-133; Osfield, S. (2012) 'This girl has special needs and one day dreams of being a mum. Does anyone have the right to stop her having a baby?' In *marie claire Magazine*, June 2012; Llewellyn, G. (1993) Parents with Intellectual Disability: Facts, Fallacies and Professional Responsibilities *Community Bulletin* 17 (1), 10 - 19.
- <sup>148</sup> WWDA (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*, Op Cit.
- <sup>149</sup> Law Reform Commission (Ireland) (2011) *Sexual Offences and Capacity to Consent: A Consultation Paper*. Law Reform Commission, Dublin.
- <sup>150</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>151</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>152</sup> Ibid.
- <sup>153</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>154</sup> Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993)
- <sup>155</sup> HGL (No 2) [2011] QCATA 259 (19 September 2011)
- <sup>156</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>157</sup> Re Katie FamCA 130 (30 November 1995)



# FOOTNOTES

- <sup>158</sup> Office of the High Commissioner for Human Rights (undated) *WORKING GROUP 4 - Evolving capacities as an enabling principle in practice*. Accessed online February 2013 at: [www2.ohchr.org/english/bodies/crc/docs/20th/BackDocWG4.doc](http://www2.ohchr.org/english/bodies/crc/docs/20th/BackDocWG4.doc)
- <sup>159</sup> Re A Teenager [1988] FamCA 17 (15 November 1988)
- <sup>160</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>161</sup> BAH [2009] NSWGT 8 (28 July 2009)
- <sup>162</sup> Jones M. & Basser Marks L. (1997) Op Cit.
- <sup>163</sup> Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993)
- <sup>164</sup> Brady, S. (2001) Op Cit.
- <sup>165</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>166</sup> Re A Teenager [1988] FamCA 17 (15 November 1988)
- <sup>167</sup> JLS v JES [1996] NSWSC 217 (21 June 1996)
- <sup>168</sup> Re Elizabeth Suit [1989] FamCA 20 (3 May 1989)
- <sup>169</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) Re Katie FamCA 130 (30 November 1995)
- <sup>170</sup> Cited in Brady, S. (2001) Op Cit.
- <sup>171</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989) Re Katie FamCA 130 (30 November 1995)
- <sup>172</sup> Online response to News article '*Parents win permission to sterilise their profoundly disabled 11-year-old daughter*'. Response posted by MissCulture 11/3/2010. Accessed online March 2010 at: <http://www.dailymail.co.uk/news/article-1256806/Australian-court-allows-parents-sterilise-11-year-old-daughter.html>
- <sup>173</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by AD of Syd at 11:30 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>174</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by Millie at 10:06 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>175</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by OddMaude at 5:08 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>176</sup> Online response to The Australian Newspaper article: *Family Court lets couple sterilise disabled daughter*; By Caroline Overington, March 09, 2010. Response posted by james of metford nsw at 10:38 AM March 09, 2010. Accessed online March 2010 at: <http://www.news.com.au/national-old/family-court-lets-couple-sterilise-disabled-daughter/story-e6frfkvr-1225838469430>
- <sup>177</sup> Sobsey, D. & Doe, T. (1991) cited in Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>178</sup> Women With Disabilities Australia (2011) *Submission to the Preparation Phase of the UN Analytical Study on Violence against Women and Girls with Disabilities (A/HRC/RES/17/11)*. Available online at: <http://www.wda.org.au/viol2011.htm>
- <sup>179</sup> Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit.
- <sup>180</sup> Between: L and GM Applicants and MM Respondent and the Director-General Department of Family Services and Aboriginal and Islander Affairs Respondent/Intervener [1993] FamCA 124; (1994) FLC 92-449 17 Fam Lr 357 Family Law (26 November 1993)
- <sup>181</sup> Department of Health & Community Services v JWB & SMB ("*Marion's Case*") [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992)
- <sup>182</sup> See the Australian Government's response to the UN Special Rapporteurs (at Appendix 3).
- <sup>183</sup> Centre for Reproductive Rights et al (2011) Op Cit.
- <sup>184</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>185</sup> Re A Teenager [1988] FamCA 17 (15 November 1988)
- <sup>186</sup> Re: Angela [2010] FamCA 98 (16 February 2010)
- <sup>187</sup> Re A Teenager [1988] FamCA 17 (15 November 1988)
- <sup>188</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>189</sup> Between: the Attorney-General of Queensland and Parents Re S [1989] FamCA 80; (1990) FLC 92-124 13 Fam Lr 660 Children (22 November 1989)
- <sup>190</sup> Cited in Transcript from 2003 Four Corners (ABC TV) Op Cit.
- <sup>191</sup> Re M (An Infant) [1992] FamCA 19 (3 April 1992).

# FOOTNOTES

- <sup>192</sup> CRC Committee General Comment No. 13 [at para.61] states: “The Committee emphasizes that the interpretation of a child’s best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child’s human dignity and right to physical integrity. An adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the Convention.” See: UN Committee on the Rights of the Child (CRC), General comment No. 13 (2011): Article 19: The right of the child to freedom from all forms of violence, 17 February 2011, CRC/C/GC/13
- <sup>193</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>194</sup> E. (Mrs.) v. Eve, [1986] 2 SCR 388; See at: <http://www.canlii.org/en/ca/scc/doc/1986/1986canlii36/1986canlii36.html>
- <sup>195</sup> Dowse, L. and Frohmader, C. (2001) Op Cit. See also: Dowse, L. (2004) Op Cit.
- <sup>196</sup> Ibid.
- <sup>197</sup> Ibid. See also: Brady, S. (2001) Op Cit.
- <sup>198</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.
- <sup>199</sup> Honourable Michael Kirby (2012) *Adult Guardianship: Law, Autonomy and Sexuality*. Paper presented at the Second World Congress on Adult Guardianship, Melbourne, Australia, 15 October 2012.
- <sup>200</sup> Department of Health & Community Services v JWB & SMB (“Marion’s Case”) [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992)
- <sup>201</sup> Brady, S. (2001) Op Cit.
- <sup>202</sup> Re H [2004] FamCA 496 (20 May 2004)
- <sup>203</sup> Re: Angela [2010] FamCA 98 (16 February 2010)
- <sup>204</sup> Re Katie FamCA 130 (30 November 1995)
- <sup>205</sup> Cited in: Center for Reproductive Rights (2010) *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis*; Center for Reproductive Rights, New York. See also: Steele, L. (2008) Op Cit., Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.; Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.; Radhika Coomaraswamy (1999), UN Doc. E/CN.4/1999/68/Add.4, Op Cit.; Brown, W. (2012) *The Word on Women – Forced sterilization and the Millennium Development Goals*. Accessed online January 2013 at: <http://www.trust.org/trustlaw/blogs/the-word-on-women/forced-sterilization-and-the-millennium-development-goals>; African Gender and Media Initiative (2012) *Robbed of Choice: Forced and Coerced Sterilization experiences of Women Living with HIV in Kenya*; Accessed online January 2013 at: <http://kelinkkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf>; Nair, P. (2011) Litigating Against Forced Sterilization if HIV-Positive Women: Recent Developments in Chile and Namibia. *Harvard Human Rights Journal*, Vol.23, pp.223-231.
- <sup>206</sup> Sifris, R. (2010) Op Cit.
- <sup>207</sup> Dowse, L. & Frohmader, C. (2001) Op Cit.; Transcript from 2003 Four Corners (ABC TV), Op Cit., WWDA (2009) *Submission to the Australian NGO Beijing+15 Review* (September 2009), available on line at: <http://www.wwda.org.au/WWDABeijingSub0909.pdf>; Osfield, S. (2012) Op Cit., Sifris, R. (2010) Op Cit., Strahan, F. (1990) *On The Record – A Report on the 1990 STAR Conference on Sterilisation: ‘My Body, My Mind, My Choice’*. Edited by Fiona Strahan, Co-Editor Lois Brudenell. Available at: <http://www.wwda.org.au/record.htm>; Personal stories communicated to WWDA by members.
- <sup>208</sup> Dowse, L. & Frohmader, C. (2001) Op Cit.; Strahan, F. (1990) Op Cit.; Personal stories communicated to WWDA by members; Women with Disabilities Feminist Collective (undated) *Women and Disability – An Issue. A Collection of writings by women with disabilities*.
- <sup>209</sup> Eastgate, G., Scheermeyer, E., van Driel, M. & Lennox, N. (2012) Intellectual disability, sexuality and sexual abuse prevention: A study of family members and support workers. *Australian Family Physician* Vol. 41, No. 3, pp. 135-139.
- <sup>210</sup> Dowse, L. & Frohmader, C. (2001) Op Cit.; Strahan, F. (1990) Op Cit.; Personal stories communicated to WWDA by members; Women with Disabilities Feminist Collective (undated) *Women and Disability – An Issue. A Collection of writings by women with disabilities*.
- <sup>211</sup> Committee on the Rights of the Child; Consideration of reports submitted by States parties under article 44 of the Convention; *Concluding observations: Australia*; Sixtieth session, 29 May–15 June 2012; CRC/C/AUS/CO/4; UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10; Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7; Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, *Concluding Observations: Australia*, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).
- <sup>212</sup> Australian Government (2012) *Draft 5th Report by Australia on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment For the period 1 January 2008 to 30 June 2012*; Attorney-General’s Department, Canberra.
- <sup>213</sup> Open Society Foundations and the Stop Torture In Health Care Campaign (2011) *Against Her Will: Forced and Coerced Sterilisation of Women Worldwide*.
- <sup>214</sup> The CRPD is underpinned by a ‘human rights’ model of disability (which upholds persons with disabilities as equal and active subjects of their rights) and guiding principles and values, which include respect for inherent dignity, autonomy, including the freedom to make one’s own choices, independence, non-discrimination, full and effective participation in society, respect for difference, and equality of opportunity.

# FOOTNOTES

- <sup>215</sup> The Committee on the Rights of Persons with Disabilities (CRPD) is the body of independent experts which monitors implementation of the Convention by the States Parties. All States parties are obliged to submit regular reports to the Committee on how the rights are being implemented. States must report initially within two years of accepting the Convention and thereafter every four years. The Committee examines each report and shall make such suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the State Party concerned. The Optional Protocol to the Convention gives the Committee competence to examine individual complaints with regard to alleged violations of the Convention by States parties to the Protocol. The Committee meets in Geneva and normally holds two sessions per year. See: <http://www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx>
- <sup>216</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain*. UN Doc. No: CRPD/C/ESP/CO/1; 19 October 2011.
- <sup>217</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Peru*. UN Doc. No: CRPD/C/PER/CO/1; 9 May 2012.
- <sup>218</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: China*. UN Doc. No: CRPD/C/CHN/CO/1; 27 September 2012.
- <sup>219</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Hungary*. UN Doc. No: CRPD/C/HUN/CO/1; 27 September 2012.
- <sup>220</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia*. UN Doc. No: CRPD/C/TUN/CO/1; 13 May 2011.
- <sup>221</sup> Committee Against Torture (CAT), *General Comment No. 2: Implementation of Article 2 by States Parties*, 24 January 2008, UN Doc. CAT/C/GC/2.
- <sup>222</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>223</sup> See: Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit.
- <sup>224</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>225</sup> Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit.
- <sup>226</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>227</sup> Committee against Torture; *Concluding observations on the combined fifth and sixth periodic reports of Peru*, adopted by the Committee at its forty-ninth session (29 October – 23 November 2012). UN Doc. No: CAT/C/PER/CO/5-6; 21 January 2013.
- <sup>228</sup> Committee against Torture; *Concluding observations of the Committee against Torture: Czech Republic*. UN Doc. No: CAT/C/CZE/CO/4-5; 13 July 2012.
- <sup>229</sup> Committee Against Torture; *Concluding Observations: Slovakia*, UN Doc. No: CAT/C/SVK/CO/2; 17 December 2009.
- <sup>230</sup> In relation to women with disabilities, CEDAW requires governments to specifically report on measures taken to ensure that disabled women can enjoy all economic, social, cultural, civil and political rights. See: UN High Commissioner for Refugees (2009) *Displacement, Statelessness and Questions of Gender Equality under the Convention on the Elimination of All Forms of Discrimination against Women*, August 2009, PPLAS/2009/02, available at: <http://www.unhcr.org/refworld/docid/4a8aa8bd2.html> [accessed 18 June 2010].
- <sup>231</sup> Grover, A. (2011) *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. United Nations General Assembly; UN Doc. A/66/254.
- <sup>232</sup> Committee on the Elimination of Discrimination against Women. *General Recommendation 19. Violence against women Article 16*. Eleventh Session, 1992, contained in UN Doc A/47/38.
- <sup>233</sup> Ibid.
- <sup>234</sup> Committee on the Elimination of Discrimination against Women; *Concluding observations on the fifth and sixth periodic reports of Chile*, adopted by the Committee at its fifty-third session (1–19 October 2012); UN Doc. CEDAW/C/CHL/CO/5-6; 12 November 2012.
- <sup>235</sup> Committee on the Elimination of Discrimination against Women; *Concluding observations: Jordan*. UN Doc. CEDAW/C/JOR/CO/5; 23 March 2012.
- <sup>236</sup> Committee on the Elimination of Discrimination against Women; *Concluding observations: Comoros*. UN Doc. CEDAW/C/COM/CO/1-4; 24 October 2012.
- <sup>237</sup> Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7.
- <sup>238</sup> Committee on the Elimination of Discrimination against Women; *Concluding observations: Czech Republic*. UN Doc. CEDAW/C/CZE/CO/5; 10 November 2010.
- <sup>239</sup> Committee on the Elimination of Discrimination against Women; Views: Communication No. 4/2004; *Ms. Andrea Szijarto v Hungary*; UN Doc. CEDAW/C/36/D/4/2004 (29 August 2006)
- <sup>240</sup> Sifris, R. (2010) Op Cit.
- <sup>241</sup> Zampas, C. & Lamackova (2011) Forced and coerced sterilization of women in Europe. *International Journal of Gynecology and Obstetrics*, Vol. 114; pp. 163–166.

# FOOTNOTES

- <sup>242</sup> See: Human Rights Committee (2000) International Covenant on Civil and Political Rights (CCPR), *General Comment No. 28: Equality of rights between men and women*, 29 March 2000, CCPR/C/21/Rev.1/Add.10, [paras.11 & 20].
- <sup>243</sup> General Assembly; Report of the Human Rights Committee, *Volume 1; Official Records*, Fifty-Fourth Session; Supplement No.40, A/54/40; para. 173.
- <sup>244</sup> Human Rights Committee; *Concluding observations: Lithuania*; adopted by the Human Rights Committee at its 105th session, 9-27 July 2012; CCPR/C/SR.2916.
- <sup>245</sup> Human Rights Committee; *Concluding observations: Slovakia*; Adopted by the Human Rights Committee at its 101st session 14 March-1 April 2011; CCPR/C/SVK/CO/3; 20 April 2011.
- <sup>246</sup> Human Rights Committee, International Covenant on Civil and Political Rights; *List of issues prior to the submission of the sixth periodic report of Australia* (CCPR/C/AUS/6), adopted by the Committee at its 106th session (15 October-2 November 2012); UN Doc No. CCPR/C/AUS/Q/6; 9 November 2012.
- <sup>247</sup> Committee on the Rights of the Child (CRC), *General Comment No. 9 (2006): The rights of children with disabilities*, 27 February 2007, CRC/C/GC/9, available at: <http://www.unhcr.org/refworld/docid/461b93f72.html> [accessed 3 March 2010]
- <sup>248</sup> Ibid.
- <sup>249</sup> Committee on the Rights of the Child (CRC), *General comment No. 13 (2011): Article 19: The right of the child to freedom from all forms of violence*, 17 February 2011, CRC/C/GC/13 [paras.16, 21].
- <sup>250</sup> *CRC Committee General Comment No.9* [at para.60]
- <sup>251</sup> *CRC Committee General Comment No. 13* [at para.61] states: "The Committee emphasizes that the interpretation of a child's best interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence. It cannot be used to justify practices, including corporal punishment and other forms of cruel or degrading punishment, which conflict with the child's human dignity and right to physical integrity. An adult's judgment of a child's best interests cannot override the obligation to respect all the child's rights under the Convention."
- <sup>252</sup> Committee on the Rights of the Child, *General Comment No 9 (2006): The Rights of Children with Disabilities*, UN Doc CRC/C/GC/9 (2007). See: <http://www.ohchr.org/english/bodies/crc/comments.htm>
- <sup>253</sup> Committee on the Rights of the Child; UN Doc. CRC/C/AUS/CO/4, Op Cit.
- <sup>254</sup> Ibid.
- <sup>255</sup> Committee on the Rights of the Child, UN Doc. CRC/C/15/Add.268, Op Cit.
- <sup>256</sup> Committee on the Rights of the Child, *Concluding observations: Austria*; UN Doc. CRC/C/15/Add.98; 29-01-1999.
- <sup>257</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations* (Art. 2, Para. 1, of the Covenant), 14 December 1990, UN Doc. E/1991/23, available at: <http://www.unhcr.org/refworld/docid/4538838e10.html> [accessed 22 June 2010]
- <sup>258</sup> Committee on Economic, Social and Cultural Rights (CESCR) (1994) *General Comment No. 5: Persons with disabilities*, 9 December 1994, UN Doc. E/1995/22.; See also: Committee on Economic, Social and Cultural Rights; *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil*. UN Doc. E/C.12/1/Add.87.; 05/23/2003.
- <sup>259</sup> CESCR General Comment No.5, Op Cit.
- <sup>260</sup> See: Hunt, P. (2005) *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, paras. 48-50, UN Doc. E/CN.4/2005/51 (Feb. 11, 2005); See also: Grover, A. (2011) UN Doc. A/66/254, Op Cit.; Grover, A. (2009) UN Doc. A/64/272, Op Cit.
- <sup>261</sup> Special Rapporteur Anand Grover also clarified that: '*Informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated. In addition to the right to health, these include the right to self-determination, freedom from discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, freedom of thought and expression and reproductive self-determination. All States parties to the International Covenant on Economic, Social and Cultural Rights have a legal obligation not to interfere with the rights conferred under the Covenant, including the right to health. Safeguarding an individual's ability to exercise informed consent in health, and protecting individuals against abuses (including those associated with traditional practices) is fundamental to protecting these rights.*' Grover, A. (2009) UN Doc. A/64/272, Op Cit.
- <sup>262</sup> Grover, A. (2009) UN Doc. A/64/272, Op Cit.
- <sup>263</sup> Grover, A. (2011). UN Doc. No: A/66/254, Op Cit.
- <sup>264</sup> From 2007 until December 2010, the Northern Territory Intervention (NTI) legislation suspended the operation of Australia's legal protection from racial discrimination, the Racial Discrimination Act 1975 (Cth) (RDA), to acts done under, or for the purposes of, the NTI. See: <http://www.hrlrc.org.au/files/Fact-Sheet-2-NT-Intervention.pdf>
- <sup>265</sup> As far back as 1999, the CERD Committee was identifying forced sterilisation of women belonging to indigenous communities as a matter of great concern. See for eg: Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Peru*; UN Doc. CERD/C/304/Add.69
- <sup>266</sup> Shirane, D. (2011) *ICERD and CERD: A Guide for Civil Society Actors*. International Movement Against All Forms of Discrimination and Racism (IMADR); IMADR Geneva Office, Switzerland.

# FOOTNOTES

- <sup>267</sup> Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Mexico*; UN Doc. CERD/C/MEX/CO/15; 4 April 2006.
- <sup>268</sup> Committee on the Elimination of Racial Discrimination; *Concluding observations of the Committee on the Elimination of Racial Discrimination: Slovakia*; UN Doc. CERD/C/65/CO/7; 10 December 2004.
- <sup>269</sup> International Conference on Population and Development (ICPD) Programme of Action, *Summary of the Programme of Action*. See: <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm>
- <sup>270</sup> The MDGs serve as a time-bound, achievable blueprint for reducing poverty and improving lives agreed to by all countries and all leading development institutions. They guide and focus development priorities for governments, donors and practitioner agencies worldwide. For more information go to: <http://www.un.org/millenniumgoals/>
- <sup>271</sup> The need for special protections guaranteeing a woman's right to informed consent is reinforced by the Beijing Declaration. Any requirement for preliminary authorisation by a third party is a violation of a woman's autonomy. See: United Nations, *The Beijing Declaration and the Platform for Action*: Fourth World Conference on Women, Beijing, China, 4-15 September 1995; A/CONF.177/20/Add.1.; See also: Grover, A. (2009) UN Doc. A/64/272, Op Cit.
- <sup>272</sup> United Nations General Assembly (2000) Resolution adopted by the General Assembly: Further actions and initiatives to implement the Beijing Declaration and Platform for Action. Twenty-third special session, UN Doc. A/RES/S-23/3
- <sup>273</sup> United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2007) *Biwako Plus Five: Further Efforts Towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific*. As adopted by the High-level Intergovernmental Meeting on the Midpoint Review of the Asian and Pacific Decade of Disabled Persons, 2003-2012, on 21 September 2007. UN Doc. E/ESCAP/APDDP(2)/2.
- <sup>274</sup> United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2002) *Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights based Society in Asia and the Pacific*. UN Doc. E/ESCAP/APDDP/4/Rev.1.
- <sup>275</sup> See for eg: The National Disability Strategy (NDS); National Disability Insurance Scheme (NDIS); National Plan to Reduce Violence against Women and their Children 2010-2022; Australia's Human Rights Framework; National Women's Health Policy (NWHPP); National Framework for Protecting Australia's Children 2009-2020
- <sup>276</sup> See: Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011;
- <sup>277</sup> Australian Law Reform Commission (2012) *Family Violence and Commonwealth Laws—People with Disability*. Access online December 2012 at: <http://www.alrc.gov.au/CFV-disability>
- <sup>278</sup> European Court of Human Rights; *I.G. and Others v. Slovakia*; (Application no. 15966/04); Judgement, Strasbourg; 13 November 2012.
- <sup>279</sup> European Court of Human Rights, case of *V. C. v Slovakia*, Application No 18968/07 (judgement delivered on 8 November 2011).
- <sup>280</sup> Centre for Reproductive Rights (17 September 2012) *Correspondence to the United Nations Committee on the Elimination of Discrimination against Women; Re: Supplementary Information on Chile*, scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women during its 53rd session (October 2012). Accessed online January 2013 at: [http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos\\_ForTheSession\\_Chile\\_CEDAW53.pdf](http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos_ForTheSession_Chile_CEDAW53.pdf)
- <sup>281</sup> See: Southern Africa Litigation Centre (30 July 2012) *Namibia: High Court Finds Govt Coercively Sterilised HIV Positive Women*. Accessed online August 2012 at: <http://allafrica.com/stories/201207301026.html>
- <sup>282</sup> Kibira, H. (23 August 2012) *Kenya: Women Seek Justice Over Sterilisation*. The Star. Accessed online January 2013 at: <http://allafrica.com/stories/201208240201.html>
- <sup>283</sup> Tegel, S. (November 8, 2011) *Peru: forced sterilization cases reopened*. The Global Post; Accessed online January 2013 at: <http://www.globalpost.com/dispatch/news/regions/americas/111107/peru-abuse-cases-reopened>
- <sup>284</sup> Sepúlveda, L. (25 July 2012) *Forced Sterilization Preys on Women with HIV-AIDs*. In Women's ENews. Accessed online January 2013 at: <http://womensenews.org/story/hivaids/120726/forced-sterilization-preys-women-hiv-aids#.UTbOQDCnB8E> See also: *F.S. V Chile* at: <http://reproductiverights.org/en/lbs-fs-vs-chile>
- <sup>285</sup> REDRESS is an organisation founded by a British torture survivor in 1992. Since then, it has consistently fought for the rights of torture survivors and their families in the UK and abroad. See: [www.redress.org](http://www.redress.org)
- <sup>286</sup> International Federation for Human Rights (FIDH) and REDRESS (27 February 2013) *Nobel Prize nominee and human rights defender Mutabar Tadjibayeva files key complaint against Uzbek government for forcible sterilisation and torture*. Accessed online February 2013 at: <http://www.redress.org/downloads/PressreleaseMutabar-270213.pdf>
- <sup>287</sup> Nelson, R. (14 January 2013) *Transgender People in Sweden No Longer Face Forced Sterilization*. TIME Newsfeed, Accessed February 2013 at: <http://newsfeed.time.com/2013/01/14/transgender-people-in-sweden-no-longer-face-forced-sterilization/>; See also: Cussins, J. (25 January 2013) *Sweden Repeals Forced Sterilization for Transgender People*. Accessed February 2013 at: <http://www.psychologytoday.com/blog/genetic-crossroads/201301/sweden-repeals-forced-sterilization-transgender-people>
- <sup>288</sup> United Nations General Assembly (2006) *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*. UN Doc. A/RES/60/147. See also: Office of the United Nations High Commissioner for Human Rights and the International Bar Association (2003) *Human Rights In The Administration Of Justice: A Manual on Human Rights for Judges, Prosecutors and Lawyers*. Professional Training Series No. 9; OHCHR, Geneva.



# FOOTNOTES

- <sup>289</sup> See UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, 2200A (XXI) United Nations, Treaty Series, vol. 999, p. 171; also Office of the United Nations High Commissioner for Human Rights and the International Bar Association (2003) Op Cit.
- <sup>290</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit., Nowak, M. (2008) UN Doc. A/HRC/7/3; Op Cit.
- <sup>291</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.
- <sup>292</sup> 'Transitional justice' refers to the set of judicial and non-judicial measures that have been implemented by different countries in order to redress the legacies of massive human rights abuses. The different elements of a comprehensive transitional justice policy are not parts of a random list, but rather, are related to one another practically and conceptually. The core elements are: *Criminal prosecutions*, particularly those that address perpetrators considered to be the most responsible; *Reparations*, through which governments recognise and take steps to address the harms suffered. Such initiatives often have material elements (such as cash payments or health services) as well as symbolic aspects (such as public apologies or day of remembrance); *Institutional reform* of abusive state institutions such as armed forces, police and courts, to dismantle—by appropriate means—the structural machinery of abuses and prevent recurrence of serious human rights abuses and impunity; *Truth commissions* or other means to investigate and report on systematic patterns of abuse, recommend changes and help understand the underlying causes of serious human rights violations. For more information see: <http://ictj.org/about/transitional-justice>
- <sup>293</sup> REDRESS (February 2013) *What is reparation? Challenges and avenues to reparation for survivors of sexual violence*, accessed online February 2013 at: <http://www.unhcr.org/refworld/docid/5134a9df2.html>
- <sup>294</sup> See Potts, H. (undated) *Accountability and the Right to the Highest Attainable Standard of Health*. Human Rights Centre, University of Essex, UK.
- <sup>295</sup> Dowse, L. & Frohmader, C. (2001) Op Cit.
- <sup>296</sup> Goldschmidt, D. (January 10th, 2012) *North Carolina task force recommends \$50,000 for sterilization victims*. InAmerica; Accessed online February 2013 at: <http://inamerica.blogs.cnn.com/2012/01/10/north-carolina-to-decide-how-much-to-compensate-victims-of-forced-sterilization/>
- <sup>297</sup> Committee on the Elimination of Discrimination against Women (2010) UN Doc. CEDAW/C/AUS/CO/7, Op Cit. See also: Australian Human Rights Commission (2012) *The Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, Australian Human Rights Commission Submission to the Senate Community Affairs References Committee.
- <sup>298</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: Peru*. UN Doc. CRPD/C/PER/CO/1; 9 May 2012.
- <sup>299</sup> Committee on the Rights of Persons with Disabilities; *Concluding observations of the Committee on the Rights of Persons with Disabilities: China*. UN Doc. CRPD/C/CHN/CO/1; 27 September 2012.
- <sup>300</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.,
- <sup>301</sup> Méndez, Juan. E. (2013) UN.Doc A/HRC/22/53, Op Cit.,
- <sup>302</sup> Grover, A. (2009) UN Doc. A/64/272, Op Cit.
- <sup>303</sup> European Court of Human Rights; *I.G. and Others v. Slovakia*; (Application no. 15966/04); Judgement, Strasbourg; 13 November 2012. European Court of Human Rights, case of *V. C. v Slovakia*, Application No 18968/07 (judgement delivered on 8 November 2011). Centre for Reproductive Rights (17 September 2012) *Correspondence to the United Nations Committee on the Elimination of Discrimination against Women; Re: Supplementary Information on Chile*, scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women during its 53rd session (October 2012). Accessed online January 2013 at: [http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos\\_ForTheSession\\_Chile\\_CEDAW53.pdf](http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CentroDeDerechosReproductivos_ForTheSession_Chile_CEDAW53.pdf) See: Southern Africa Litigation Centre (30 July 2012) *Namibia: High Court Finds Govt Coercively Sterilised HIV Positive Women*. Accessed on line August 2012 at: <http://allafrica.com/stories/201207301026.html>; Tegel, S. (November 8, 2011) *Peru: forced sterilization cases reopened*. The Global Post; Accessed online January 2013 at: <http://www.globalpost.com/dispatch/news/regions/americas/111107/peru-abuse-cases-reopened>
- <sup>304</sup> The Aquinas Program: Truth in Society 2008-2009, *Leilani Muir and the Alberta Government*, accessed online February 2013 at: <http://people.stu.ca/~truth/0809/reports/eugenics.pdf>; See also: *Leilani Muir successfully sues Alberta govt for wrongful sterilization*, The Current, Monday, November 14, 2011. Accessed online February 2013 at: <http://www.cbc.ca/thecurrent/episode/2011/11/14/leilani-muir-successfully-sues-alberta-govt-for-wrongful-sterilization/>
- <sup>305</sup> Dowse, L. & Frohmader, C. (2001) Op Cit.
- <sup>306</sup> Pasulka, N. (January 25, 2012) *Forced Sterilization for Transgender People in Sweden*. Accessed online at: <http://www.motherjones.com/mixed-media/2012/01/sweden-still-forcing-sterilization>
- <sup>307</sup> For more information on the *North Carolina Justice for Sterilization Victims Foundation*, go to: <http://www.sterilizationvictims.nc.gov/>
- <sup>308</sup> North Carolina Justice for Sterilization Victims Foundation, 'Governor's Task Force to Determine the Method of Compensation for Victims of North Carolina's Eugenics Board'. Accessed online February 2013 at: <http://www.sterilizationvictims.nc.gov/taskforce.aspx>
- <sup>309</sup> Governor's Task Force to Determine the Method of Compensation for Victims of North Carolina's Eugenics Board (2012) *Final Report to the Governor of the State of North Carolina*; Pursuant to Executive Order 83; Accessed on line January 2013 at: <http://www.sterilizationvictims.nc.gov/documents/FinalReport-GovernorsEugenicsCompensationTaskForce.pdf>
- <sup>310</sup> REDRESS (September 2010) *Rehabilitation as a Form of Reparation: Opportunities and Challenges Workshop Report*, Accessed online February 2013 at: [http://www.redress.org/downloads/publications/Report\\_of\\_the\\_Expert\\_Seminar\\_on\\_Rehabilitation\\_October\\_2010.pdf](http://www.redress.org/downloads/publications/Report_of_the_Expert_Seminar_on_Rehabilitation_October_2010.pdf)
- <sup>311</sup> Somasundaram, D., cited in REDRESS (September 2010) *Rehabilitation as a Form of Reparation: Opportunities and Challenges Workshop Report*, Accessed online February 2013 at: [http://www.redress.org/downloads/publications/Report\\_of\\_the\\_Expert\\_Seminar\\_on\\_Rehabilitation\\_October\\_2010.pdf](http://www.redress.org/downloads/publications/Report_of_the_Expert_Seminar_on_Rehabilitation_October_2010.pdf)



# FOOTNOTES

<sup>312</sup> CRPD Article 26 (Habilitation and rehabilitation) states:

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
  - (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
  - (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

<sup>313</sup> UN General Assembly (2000) *Further actions and initiatives to implement the Beijing Declaration and Platform for Action*. Resolution adopted by the General Assembly: S-23/3.A/RES/S-23/3 [para.27].

<sup>314</sup> Women With Disabilities Australia (WWDA) (2009) *Parenting Issues for Women with Disabilities in Australia: A Policy Paper*. OpCit.

<sup>315</sup> Manjoo, Rashida (2012) UN Doc. A/67/227, Op Cit.

<sup>316</sup> Dowse, L. and Frohmader, C. (2001) Op Cit.

<sup>317</sup> Dowse, L. (2004) *'Moving Forward or Losing Ground? The Sterilisation of Women and Girls with Disabilities in Australia'*. Paper presented to Disabled Peoples' International (DPI) World Summit, Winnipeg, September 8-10, 2004. Available online at: <http://www.wwda.org.au/steril3.htm> ; Steele, L. (2008) Making sense of the Family Court's decisions on the non-therapeutic sterilisation of girls with intellectual disability; *Australian Journal of Family Law*, Vol.22, No.1.; Prilleltensky, O. (2003) A Ramp to Motherhood: The Experiences of Mothers with Physical Disabilities. *Sexuality and Disability*, Vol. 21, No. 1, pp. 21-47.

<sup>318</sup> See for example: the Sexuality Education Counselling and Consultancy Agency (SECCA) in Western Australia, provides education and training workshops which are able to be customised. One example is the 'Menstrual Management, Personal Hygiene & Sexual Health' Training Workshop which aims to 'provide participants with strategies to teach women with a disability, their carers and other health professionals a positive approach to menstruation'. SECCA also provides a one-on-one specialist counselling and education service in the area of human relationships and sexuality to people who have a disability, their family and significant carers.

<sup>319</sup> Women With Disabilities Australia (2011) *Submission to the Preparation Phase of the UN Analytical Study on Violence against Women and Girls with Disabilities* (A/HRC/RES/17/11). Available online at: <http://www.wwda.org.au/viol2011.htm>





Women  
With  
Disabilities  
Australia  
(WWDA)



Women  
With  
Disabilities  
Australia  
(WWDA)

# DEHUMANISED

**THE FORCED STERILISATION  
OF WOMEN AND GIRLS WITH  
DISABILITIES IN AUSTRALIA**

## APPENDICES

# DEHUMANISED

## **'DEHUMANISED: THE FORCED STERILISATION OF WOMEN AND GIRLS WITH DISABILITIES IN AUSTRALIA'**

WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia

*By Carolyn Frohmader for Women With Disabilities Australia (WWDA)*

© Women With Disabilities Australia (WWDA) March 2013

ISBN 978-0-9876035-0-0

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without written permission from Women With Disabilities Australia (WWDA). All possible care has been taken in the preparation of the information contained in this document. WWDA disclaims any liability for the accuracy and sufficiency of the information and under no circumstances shall be liable in negligence or otherwise in or arising out of the preparation or supply of any of the information aforesaid.

This publication has been prepared by Women with Disabilities Australia Inc. for the Australian Government, represented by the Department of Families, Housing, Community Services and Indigenous Affairs. The views expressed in this publication are those of Women with Disabilities Australia Inc. and do not necessarily represent the views of the Australian Government.

### **ABOUT WOMEN WITH DISABILITIES AUSTRALIA (WWDA)**

Women With Disabilities Australia (WWDA)<sup>1</sup> is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA's work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the reproductive rights of women and girls with disabilities, along with promoting their rights to freedom from violence and exploitation, and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.<sup>2</sup>

### **WOMEN WITH DISABILITIES AUSTRALIA (WWDA)**

PO Box 605, Rosny Park 7018 Tasmania, Australia

**Ph** +61 3 62448288

**Fax** +61 3 62448255

**Email** [wwda@wwda.org.au](mailto:wwda@wwda.org.au)

**Web** [www.wwda.org.au](http://www.wwda.org.au)

**Facebook** [www.facebook.com/WWDA.Australia](https://www.facebook.com/WWDA.Australia)

Winner, National Human Rights Award 2001

Winner, National Violence Prevention Award 1999

Winner, Tasmanian Women's Safety Award 2008

Certificate of Merit, Australian Crime & Violence Prevention Awards 2008

Nominee, French Republic's Human Rights Prize 2003

Nominee, UN Millennium Peace Prize for Women 2000



# CONTENTS

<b>Appendices</b>	<b>4</b>
FIGO Guidelines on Female Contraceptive Sterilisation	5
Letter to the Australian Government from the UN Special Rapporteurs	8
Responses from the Australian Government to the UN Special Rapporteurs	11
Senate Inquiry Terms of Reference	41
<b>Footnotes</b>	<b>42</b>





# APPENDICES

# APPENDIX 1

## FIGO GUIDELINES



### FEMALE CONTRACEPTIVE STERILIZATION

#### BACKGROUND

1. Human rights include the right of individuals to control and decide on matters of their own sexuality and reproductive health, free from coercion, discrimination and violence. This includes the right to decide whether and when to have children, and the means to exercise this right.
2. Surgical sterilization is a widely used method of contraception. An ethical requirement is that performance be preceded by the patient's informed and freely given consent, obtained in compliance with the Guidelines Regarding Informed Consent (2007) and on Confidentiality (2005). Information for consent includes, for instance, that sterilization should be considered irreversible, that alternatives exist such as reversible forms of family planning, that life circumstances may change, causing a person later to regret consenting to sterilization, and that procedures have a very low but significant failure rate.
3. Methods of sterilization generally include tubal ligation or other methods of tubal occlusion. Hysterectomy is inappropriate solely for sterilization, because of disproportionate risks and costs.
4. Once an informed choice has been freely made, barriers to surgical sterilization should be minimised. In particular: a) sterilization should be made available to any person of adult age; b) no minimum or maximum number of children may be used as a criterion for access; c) a partner's consent must not be required, although patients should be encouraged to include their partners in counseling; d) physicians whose beliefs oppose participation in sterilization should comply with the Ethical Guidelines on Conscientious Objection (2005).
5. Evidence exists, including by governmental admission and apology, of a long history of forced and otherwise non-consensual sterilizations of women, including Roma women in Europe and women with disabilities. Reports have documented the coerced sterilization of women living with HIV/AIDS in Africa and Latin America. Fears remain that ethnic and racial minority, HIV-positive, low-income and drug-using women, women with disabilities and other vulnerable women around the world, are still being sterilized without their own freely-given, adequately informed consent.
6. Medical practitioners must recognize that, under human rights provisions and their own professional codes of conduct, it is unethical and in violation of human rights for them to perform procedures for prevention of future pregnancy on women who have not freely requested such procedures, or who have not previously given their free and informed consent. This is so even if such procedures are recommended as being in the women's own health interests.
7. Only women themselves can give ethically valid consent to their own sterilization. Family members including husbands, parents, legal guardians, medical practitioners and, for instance, government or other public officers, cannot consent on any woman's or girl's behalf.

# APPENDIX 1

## FIGO GUIDELINES

8. Women's consent to sterilization should not be made a condition of access to medical care, such as HIV/ AIDS treatment, natural or cesarean delivery, or abortion, or of any benefit such as medical insurance, social assistance, employment or release from an institution. In addition, consent to sterilization should not be requested when women may be vulnerable, such as when requesting termination of pregnancy, going into labor or in the aftermath of delivery.
9. Further, it is unethical for medical practitioners to perform sterilization procedures within a government program or strategy that does not include voluntary consent to sterilization.
10. Sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she will not become pregnant immediately, and therefore must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health.
11. As for all non-emergency medical procedures, women should be adequately informed of the risks and benefits of any proposed procedure and of its alternatives. It must be explained that sterilization must be considered a permanent, irreversible procedure that prevents future pregnancy, and that non-permanent alternative treatments exist. It must also be emphasized that sterilization does not provide protection from sexually transmitted infections. Women must be advised about and offered follow-up examinations and care after any procedure they accept.
12. All information must be provided in language, both spoken and written, that the women understand, and in an accessible format such as sign language, Braille and plain, non-technical language appropriate to the individual woman's needs. The physician performing sterilization has the responsibility of ensuring that the patient has been properly counseled regarding the risks and benefits of the procedure and its alternatives.
13. The U.N. Convention on the Rights of Persons with Disabilities includes recognition "that women and girls with disabilities are often at greater risk ... of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation". Accordingly, Article 23(1) imposes the duty "to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
  - a) The right of all persons with disabilities who are of marriageable age to marry and to found a family ... is recognized;
  - b) The rights...to decide freely and responsibly on the number and spacing of their children ...are recognized, and the means necessary to enable them to exercise these rights are provided;
  - c) Persons with disabilities, including children, retain their fertility on an equal basis with others".

# APPENDIX 1

## FIGO GUIDELINES

### RECOMMENDATIONS

1. No woman may be sterilized without her own, previously-given informed consent, with no coercion, pressure or undue inducement by healthcare providers or institutions.
2. Women considering sterilization must be given information of their options in the language in which they communicate and understand, through translation if necessary, in an accessible format and plain, non-technical language appropriate to the individual woman's needs. Women should also be provided with information on non-permanent options for contraception. Misconceptions about prevention of sexually transmitted diseases (STDs) including HIV by sterilization need to be addressed with appropriate counseling about STDs.
3. Sterilization for prevention of future pregnancy is not an emergency procedure. It does not justify departure from the general principles of free and informed consent. Therefore, the needs of each woman must be accommodated, including being given the time and support she needs, while not under pressure, in pain, or dependent on medical care, to consider the explanation she has received of what permanent sterilization entails and to make her choice known.
4. Consent to sterilization must not be made a condition of receipt of any other medical care, such as HIV/AIDS treatment, assistance in natural or cesarean delivery, medical termination of pregnancy, or of any benefit such as employment, release from an institution, public or private medical insurance, or social assistance.
5. Forced sterilization constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies. Healthcare providers have an ethical response in accordance with the guideline on Violence Against Women (2007).
6. It is ethically inappropriate for healthcare providers to initiate judicial proceedings for sterilization of their patients, or to be witnesses in such proceedings inconsistently with Article 23(1) of the Convention on the Rights of Persons with Disabilities.
7. At a public policy level, the medical profession has a duty to be a voice of reason and compassion, pointing out when legislative, regulatory or legal measures interfere with personal choice and appropriate medical care.

# APPENDIX 2

## LETTER TO THE AUSTRALIAN GOVERNMENT FROM THE UNITED NATIONS SPECIAL RAPPORTEURS

Goa, March 2011  
NATIONS UNIES  
HAUT COMMISSARIAT DES NATIONS UNIES  
AUX DROITS DE L'HOMME

PROCEDURES SPECIALES DU  
CONSEIL DES DROITS DE L'HOMME

UNITED NATIONS  
OFFICE OF THE UNITED NATIONS  
HIGH COMMISSIONER FOR HUMAN RIGHTS

SPECIAL PROCEDURES OF THE  
HUMAN RIGHTS COUNCIL

Mandates of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences

REFERENCE: AL Health (2002-7) G/SO 214 (89-15)  
AUS 2/2011

18 July 2011

Excellency,

We have the honour to address you in our capacities as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and Special Rapporteur on violence against women, its causes and consequences pursuant to General Assembly resolution 60/251 and to Human Rights Council resolutions 15/22 and 16/7.

In this connection, we would like to bring to the attention of your Excellency's Government information we have received concerning the alleged ongoing practice of non-therapeutic, forced sterilization of girls and women with disabilities in Australia.

According to the information received:

It is alleged that non-therapeutic, forced sterilization is performed on young girls and women with disabilities for various purposes, including pregnancy prevention, population control, menstrual management and personal care. Reportedly, non-therapeutic sterilization is sterilization for a purpose other than to treat some malfunction or disease, and it refers to procedures carried out in circumstances that do not involve a serious threat to the health or life of the individuals. Forced sterilization refers to sterilization that has occurred in the absence of the individual's consent.

It is also alleged that cases of non-therapeutic, forced sterilization of girls have occurred in greater numbers than those formally authorized by courts and tribunals. It is further alleged that the existing State and Territory legislation and federal court mechanisms have not adequately addressed non-therapeutic, forced sterilizations of young girls with disabilities, in particular with regard to preventing such children from being taken out of Australia for sterilization procedures elsewhere.

While we do not wish to prejudge the accuracy of these allegations, we would appreciate information from your Government on the steps taken by the competent authorities with a view to ensuring the right to the highest attainable standard of health of girls and women with disabilities. This right is enshrined, inter alia, in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ratified on 10 December 1975), which provides for the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. This includes an obligation on the part of all States parties to ensure that health facilities, goods and services are accessible to everyone, especially the most vulnerable or marginalized sections of the population, without discrimination. In that connection, General Comment No. 14 of the Committee on Economic, Social and Cultural Rights elucidates



# APPENDIX 2

## LETTER TO THE AUSTRALIAN GOVERNMENT FROM THE UNITED NATIONS SPECIAL RAPPORTEURS

that the right to health contains both freedoms and entitlements and holds that “the freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation” (para. 8). I would also like to refer your Excellency’s Government to General Comment No. 5 of the Committee, which holds that “Women with disabilities also have the right to protection and support in relation to motherhood and pregnancy...Both the sterilization of, and the performance of an abortion on, a woman with disabilities without her prior informed consent are serious violations of article 10 (2) [of the International Covenant on Economic, Social and Cultural Rights]” (para.30).

We would like to draw the attention of your Excellency’s Government to Article 17 of the Convention on the Rights of Persons with Disabilities (ratified on 17 July 2008), which states: “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others”. We would also like to refer your Excellency’s Government to Article 23 of the Convention, which holds that “States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that: (...) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized.”

Furthermore, we would like to draw the attention of your Excellency’s Government to Article 24 of the Convention on the Rights of the Child (ratified on 17 Dec 1990), which holds that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. I would also like to refer your Excellency’s Government to General Comment No.9 of the Committee of the Rights of the Child which states: “The Committee is deeply concerned about the prevailing practice of forced sterilisation of children with disabilities, particularly girls with disabilities. This practice, which still exists, seriously violates the right of the child to her or his physical integrity and results in adverse life-long physical and mental health effects. Therefore, the Committee urges States parties to prohibit by law the forced sterilisation of children on grounds of disability.”

We would also like to refer your Excellency’s Government to General Recommendation No. 18 of the Committee on the Elimination of Discrimination against Women, which recommends that “States parties [to the Convention in the Elimination of all Forms of Discrimination against Women (ratified on 28 July 1983)] provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life”. In that context, I would like to note paragraph 43 of the Concluding observations of the Committee on the Elimination of Discriminations against Women (CEDAW/C/AUL/CO/7, 30.07.2010) which recommended that Australia “enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilization of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent”.

Finally, we deem it appropriate to make reference to Commission on Human Rights Resolution 2005/41 on the Elimination on Violence against women, which provides that women should be empowered to protect themselves against violence and, in this regard, stresses that women have the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. In this context, we would also like to draw your attention to the Platform for Action of the Beijing World Conference on Women and the Programme of Action of the Cairo International Conference on Population and Development, which reaffirm the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.



# APPENDIX 2

## LETTER TO THE AUSTRALIAN GOVERNMENT FROM THE UNITED NATIONS SPECIAL RAPPORTEURS

We urge your Excellency's Government to take all necessary measures to ensure the protection and full enjoyment of the right to the highest attainable standard of health for girls and women with disabilities in accordance with international standards.

It is our responsibility under the mandate provided by the Human Rights Council to seek to clarify all cases brought to my attention regarding the right to health. Since we are expected to report on these cases to the Council, we would be grateful for your cooperation in addressing the following matters:

1. Are the facts alleged in the above summary of the case accurate?
2. Please provide details of any actions to prevent further non-therapeutic, forced sterilization of girls and women with disabilities?
3. Please provide details of any actions to sanction medical staff carrying out illegal non-therapeutic, forced sterilizations of girls and women with disabilities. Please provide details, and where available the results, of any investigation and judicial or other inquiries carried out in relation to such cases. If no inquiries have been made, or if they have been inconclusive, please explain why.
4. Please provide details of any actions to ensure that reparation, including compensation and rehabilitation, is provided to those girls and women with disabilities who may have been forcibly sterilized?
5. Please provide details of any actions to ensure that informed consent requirements are adequately implemented for all medical interventions with regard to children and persons with disabilities?
6. What measures are being taken to ensure the enjoyment of the right to health of girls and women with disabilities?

We undertake to ensure that your Excellency's Government's response to each of these questions is accurately reflected in the reports that will be submitted to the Human Rights Council for its consideration.

Please accept, Excellency, the assurances of our highest consideration.

Anand Grover  
Special Rapporteur on the right of everyone to the enjoyment of the  
highest attainable standard of physical and mental health

Rashida Manjoo  
Special Rapporteur on violence against women, its causes and consequences

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS



Note Number: 108/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

The Australian Government has the honour to refer to the Special Rapporteurs' letter of 18 July 2011 requesting the Australian Government's observations on the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

The Australian Government is currently considering the information and questions contained in the letter. The Government is consulting with relevant stakeholders, including state and territory governments, and will provide a full response by 17 October 2011.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteurs the assurances of its highest consideration.

Geneva  
12 August 2011



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS



Note Number: 127/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

The Australian Government has the honour to refer to the Special Rapporteurs' letter of 18 July 2011 requesting the Government's response regarding the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

The Australian Government has the further honour to refer to its correspondence of 12 August 2011, in which the Special Rapporteurs were informed that a response would be provided by the Australian Government by 17 October 2011.

The Australian Government is currently considering the information and questions contained in the letter of 18 July 2011. The Commonwealth Attorney-General's Department is in the process of compiling a detailed Australian Government response to this request for information.

The Australian Government regrets that in order to ensure the Australian Government's response to this request is as comprehensive as possible, further consultation with the State and Territory governments is required, and consequently it is unlikely that this consultation will be completed before the earlier indicated date for submission of 17 October 2011.

The Australian Government is committed to upholding its international obligations and would prefer to take more time to ensure an accurate and fully considered response can be prepared on this important topic.

The Australian Government regrets this delay in response and will submit its final response to the Special Rapporteurs by 16 December 2011.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.



**OHCHR REGISTRY**

- 5 OCT. 2011

Recipients :.....SPD.....  
.....

Australian Permanent Mission to the UN  
Chemin des Fins 2 – Case Postale 102 – 1211 Geneve 19 Tel. 022 799 91 00 Fax 022 799 91 75

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS



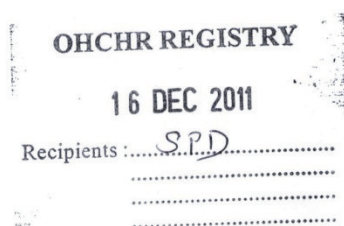
Note number: 185/2011

The Australian Permanent Mission to the United Nations in Geneva presents its compliments to the Office of the High Commissioner for Human Rights, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.

The Australian Government has the honour to refer to the Special Rapporteurs' letter of 18 July 2011 requesting the Government's response regarding the alleged practice of non-therapeutic, forced sterilisation of girls and women with disabilities in Australia.

The Australian Government has the further honour to enclose, for the Special Rapporteurs' consideration, its response to the issues raised in that letter.

The Australian Permanent Mission to the United Nations avails itself of this opportunity to renew to the Office of the High Commissioner for Human Rights and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Special Rapporteur on violence against women, its causes and consequences.



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### **UNITED NATIONS OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS SPECIAL RAPPORTEURS' REQUEST FOR INFORMATION**

### **ALLEGATIONS OF NON-THERAPEUTIC FORCED STERILISATION OF GIRLS AND WOMEN WITH DISABILITIES IN AUSTRALIA**

Australia is party to the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC).

The Australian Government welcomes the Special Rapporteurs' interest in Australian law and practice concerning sterilisation.

Australia has recently submitted its initial report under the CRPD and, as that report notes, persons with disabilities are highly valued members of Australian communities and workplaces and make a positive contribution to Australian society. Moreover, the Australian Government is committed to improving and enriching the lives of all women to enable them to participate equally in all aspects of Australian life.

The Australian Government notes that the issue of Australian practices in relation to sterilisation of people with disabilities was raised in the course of Australia's recent Human Rights Universal Periodic Review (UPR).<sup>1</sup> In response to concerns expressed internationally and domestically, the then Commonwealth Attorney-General undertook to initiate further discussions with State and Territory counterparts on this issue. This consultation is ongoing at this time.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### 1. ARE THE FACTS ALLEGED IN THE SUMMARY OF THE CASE ACCURATE?

The Australian Government is committed to respecting the human rights of all persons with disabilities, including their right to personal integrity and reproductive rights. Sterilisation is a serious and irreversible procedure. Many people choose sterilisation as a method for controlling their fertility, but sterilisation can have significant physical and psychological consequences for those who undergo it. Sterilisations should never be carried out in the absence of a person's free and informed consent where that person is capable of making the decision, including where a person requires support to make that decision.

The Government takes its international human rights obligations seriously and has noted the concerns raised domestically and internationally regarding Australia's approach to sterilisation of children and adults with disabilities. The former Attorney-General has asked the Attorney General's Department to consider options for reform in this area and has undertaken to raise this issue with State and Territory counterparts. This work will form part of the Government's National Human Rights Action Plan, the draft of which was launched to coincide with International Human Rights Day, 10 December 2011.

Under current laws, for children and adults who have an impaired capacity to consent and are unable to make an independent decision about whether to undergo a sterilisation procedure, Australian laws provide for authorisation by a court or guardianship tribunal. These laws are designed to protect the rights of those involved and to ensure procedures are authorised only where they are in the person's best interests.

Detail of the different laws governing sterilisation in Australia is set out below, however, broadly, in all Australian jurisdictions the authorisation of a court or tribunal is required in cases where a sterilisation procedure is not considered to be clearly therapeutic (the requirements vary between jurisdictions but would include, for example, surgery to remove a cancer). This is a greater protection than is applied for most other medical treatments, recognising the serious nature of sterilisation procedures and the possible challenges for carers to objectively determine what is in the person's best interests.

Courts and tribunals hear a range of evidence; often including the views of the person concerned, medical evidence and evidence from carers. In many cases, an independent advocate is appointed to represent the person's interests to the court or tribunal. Appointment of an independent advocate is usually a matter for the Court or Tribunal to decide. Sterilisations are authorised only where they are the last resort, as less invasive options have failed or are inappropriate, and where they are in the person's best interests.

A review conducted at the behest of the Standing Committee of Attorney General's (SCAG), the national ministerial council made up of the Australian Attorney-General and the State and Territory Attorneys-General, indicated in 2006 that sterilisations of children with an intellectual disability had declined significantly since Australia's 1997 country report to the Committee on the Elimination of All Forms of Discrimination Against Women. Evidence also indicated that alternatives to surgical procedures to manage the menstruation and contraceptive needs of girls and women with disabilities are increasingly available and seem to be successful in the most part.

The Australian Government recognises that the issues faced by children and women with disabilities and their parents and carers in these situations are sensitive, and that members of the community have strong concerns about children and women with disabilities being subjected to medical procedures which result in sterilisation.



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The Australian Government would be very concerned if concrete evidence were made available that demonstrated that current mechanisms were not adequately protecting girls and women with disabilities, or that cases of sterilisation that are unlawful without court or tribunal authorisation had occurred in greater numbers than those formally authorised. The Australian Government would also be concerned if children with disabilities were being taken out of Australia for sterilisation procedures elsewhere that would be unlawful without court or tribunal authorisation in Australia. However the Australian Government is unaware of any such evidence at this time.

### **2. PLEASE PROVIDE DETAILS OF ANY ACTIONS TO PREVENT FURTHER NON THERAPEUTIC, FORCED STERILISATION OF GIRLS AND WOMEN WITH DISABILITIES.**

The Australian Government recognises the right of persons with disabilities to retain their fertility on an equal basis with others. Given its serious consequences sterilisation (of a child or of an adult with a disability who is unable to give consent), that is not performed to cure a disease or correct some malfunction, may only be authorised by a court or tribunal as a measure of last resort. In many cases, an independent advocate is appointed to represent the person's interests to the court or tribunal.

#### **A NATIONAL APPROACH?**

Australia is a federation with nine separate jurisdictions, the Commonwealth or federal jurisdiction and eight State and Territory jurisdictions. The 2006 SCAG review considered model legislation on a nationally consistent approach, which would have applied to the authorisation procedures required for the lawful sterilisation of minors across all the jurisdictions.

After deliberation and the review of findings presented by a working group, it was decided that there would be limited benefit in developing such model legislation at that point in time.

SCAG agreed instead to review State and Territory arrangements to ensure that all tribunals, or bodies with the power to make orders concerning the sterilisation of minors with an intellectual disability, are required to be satisfied before such an order is made that all less invasive alternatives to sterilisation are inappropriate or have been tried and found to be unsuccessful.

Subsequently, across the jurisdictions the legal framework currently applied to prevent unnecessary sterilisation of children and of women who are unable to independently consent differs. In 2011 the then Commonwealth Attorney-General undertook to initiate further discussions with State and Territory counterparts on this issue. These discussions are ongoing at this time and may influence future change to the Federal, State and Territory legal frameworks. In the interim, the following information outlines the current requirements in each jurisdiction.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### COMMONWEALTH JURISDICTION

At the federal level, the Family Court of Australia (Family Court) has jurisdiction under the *Family Law Act 1975* to make orders relating to the welfare of children, such as to authorise special medical procedures for children, including sterilisation that is not to treat a disease or correct some malfunction. The Family Court has a general welfare jurisdiction that enables the court to give consent to special medical procedures in place of the parents where the consent required is outside the bounds of parental authority. When considering a request the court must regard the child's best interests as the paramount consideration in these decisions. The following information outlines the approach taken by the courts in such cases.

Parent or guardian consent to sterilisation will be sufficient only where sterilisation is a by-product of surgery appropriately carried out to treat a malfunction or disease. In addition, a medical practitioner can lawfully carry out a sterilisation procedure in emergency situations, that is, where the procedure is necessary to save a person's life or to prevent serious damage to that person's health.

Where a child cannot consent due to a lack of maturity or a disability, court or tribunal approval is required for serious medical procedures including sterilisation. The Family Court is empowered to make such decisions, and in doing so is required to treat the best interests of the child as the paramount consideration

### MARION'S CASE

The High Court of Australia (HCA) established the framework for authorisation of sterilisation of children in Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992),<sup>2</sup> on appeal from the Family Court. This appeal considered the processes required to authorise procedures that would render a 14 year old girl with intellectual disabilities infertile but prevent menstruation, pregnancy and hormonal fluxes and consequently reduce psychological and behavioural problems.

A majority judgement held that children who have a sufficient understanding and intelligence to enable them to understand fully what is proposed are capable of giving (or withholding) informed consent. The majority also held that where a child is insufficiently mature to give consent on his or her own behalf then, as a general rule, his or her parents or guardian have lawful authority to consent to medical treatment of the child, provided that the treatment is in the child's best interests.

The HCA acknowledged the uncertainty in the term 'therapeutic', but defined it to mean sterilisation that is 'a by-product of surgery appropriately carried out to treat some malfunction or disease.' The majority found that the parental power to consent to a sterilisation procedure is limited to circumstances in which sterilisation is therapeutic in this sense, because sterilisation 'requires invasive, irreversible and major surgery.'

Accordingly, only a court or tribunal, that has a relevant welfare jurisdiction, has the power to authorise sterilisation procedures that are not carried out as a by-product of surgery appropriately carried out to treat some malfunction or disease. The majority went on to provide guidance on the issues a court should consider when asked to give authorisation for such sterilisation and held that the court must decide 'whether, in the circumstances of the case, [authorisation of sterilisation] is in the best interests of the child' (the 'best interests test'). The HCA noted that within that context, sterilisation can only be authorised where other procedures or

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

treatments are or have proved to be inadequate, have failed, or will not 'alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.'

Thus, a best interest test is applied by the Family Court throughout Australia when determining whether to authorise the sterilisation of a minor (*Marion's Case*). The *Family Law Rules 2004* set out evidence that must be considered in applying the best interests test. Additional details on these Rules are provided below. In addition, Family Court may appoint an independent children's lawyer to represent the child's best interests.

### ANGELA'S CASE

An recent example of the application of the *Family Law Rules* and the test in *Marion's Case* can be found in *Re Angela (Special Medical Procedure)*, where the Family court authorised the performance of a hysterectomy on an eleven year old girl with a decision making disability.<sup>3</sup>

Angela suffered from heavy menstrual bleeding and was anaemic. She also had epileptic seizures around the time of menstruation and menstruation brought pain, fatigue and hygiene discomfort. The judge found that Angela would 'never be in a position to make a decision about her own welfare'. Overall the judge was satisfied in this case that sterilisation was a last resort treatment that would contribute to an improvement in Angela's quality of life. The Family Court decided not to appoint an independent children's lawyer in this case.

### MEDICARE BENEFITS

In addition to the legal framework set up at the Commonwealth level to assess applications for sterilisation, there are additional protections provided through the regulations of the Medicare Benefits Schedule (MBS).

Through the MBS, the Australian Government facilitates universal access to allied health, general practice and specialist medical services by subsidising fee-for-service care. No Medicare benefits are payable for services which are provided in contravention of Commonwealth or State and Territory laws.

Medicare benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3(1) of the *Health Insurance Act 1973*. Section 3(1) states that a clinically relevant service must be provided by a medical practitioner in accordance with accepted medical practice.

The MBS does not provide any specific information on the sterilisation of the girls or women with disabilities, however, the following information is provided in relation to the sterilisation of minors:

- It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (e.g. malignancies of the reproductive tract) unless legal authorisation has been obtained.
- Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court or another court or tribunal with jurisdiction to give such authorisation.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### STATE AND TERRITORY JURISDICTIONS

In addition, the various Australian States and Territories have developed their own procedures for authorising the sterilisation of children and adults who do not have the capacity to consent on their own behalf. All States and Territories have their own procedures for adults, however New South Wales, Queensland, South Australia and Tasmania also have provisions for children. These procedures operate concurrently to the Family Court procedure for authorising sterilisations in the best interests of the child. The following information outlines the current legal requirements in various jurisdictions:

#### VICTORIA

Victorian legislation provides that involuntary treatments such as sterilisations and abortions can only be carried out by order of the Victorian Civil and Administrative Tribunal (VCAT).

Under the Victorian *Guardianship and Administration Act 1986* a 'special procedure' is defined to include: 'any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out'; 'termination of pregnancy'; and 'any removal of tissue for the purposes of transplantation to another person'.

The *Guardianship and Administration Act 1986* sets out the manner in which the VCAT may consent to the performance of a 'special procedure' where the person in question is unable to give consent and the procedure would be in the patient's best interests. This Act only applies to a person who is aged 18 years of over.

The Victorian Office of the Public Advocate (OPA) must be given notice of any application and is entitled to participate in the case. The OPA's role in these applications is to assist VCAT to make a decision that is in a person's best interests by gathering information about the person's disability and their ability to make decisions about the proposed special procedure. The OPA is also occasionally involved as an *amicus curiae*, and sometimes even as a party, in Family Court cases where medical treatment decisions concerning children are being considered.

A decision of the Tribunal is reviewable by the superior courts. The *Guardianship and Administration Act 1986* provides quite severe penalties for any medical practitioner who carries out a special procedure without having obtained the proper consent.

While the *Guardianship and Administration Act 1986* is currently being reviewed by the Victorian Law Reform Commission, there is no indication at present that the Commission will make any recommendations to reform the provisions relating to obtaining consent for forced sterilisations and abortion.<sup>4</sup>

#### NEW SOUTH WALES

In NSW, two different legal regimes are in place to govern the sterilisation of children and adults. For children aged under 16, the provisions contained within section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) apply. For people aged 16 and over who are incapable of giving consent to medical treatment, the regime under the *Guardianship Act 1987* (NSW) applies.

Under section 175(1) of the *Care and Protection Act 1998*, it is an offence to carry out special medical treatment on a child that is not in accordance with the provisions of this section. Special medical treatment includes

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

non-therapeutic sterilisation, that is, medical treatment that is intended, or is reasonably likely to render a person permanently infertile. Section 175(2) of this Act provides that non-therapeutic sterilisation may only be performed in an emergency to save the child's life or prevent serious damage to health, or with the approval of the Guardianship Tribunal which must apply similar criteria when determining whether to give consent.

A person under 16 is entitled to be legally represented in proceedings before the Guardianship Tribunal. This representation is available free of charge through Legal Aid, with no means or merit tests applied.

Under the provisions of the *Guardianship Act 1987*, only the Guardianship Tribunal can consent to 'special treatment' of a person aged over 16 who is incapable of giving consent. Special treatment is defined to include 'any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out.'

Two exceptions apply under the provisions this Act:

- (a) The guardian of a patient may also consent to the carrying out of continuing or further special treatment if the Tribunal has previously given consent to the carrying out of the treatment and has authorised the guardian to give consent to the continuation of that treatment or to further treatment of a similar nature.
- (b) If the medical practitioner carrying out or supervising the treatment considers the treatment is necessary, as a matter of urgency to save the patient's life or to prevent serious damage to the patient's health.

The *Guardianship Act 1987* requires that the Tribunal must not consent to the carrying out of the treatment unless it is satisfied that it is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being. Further, the Tribunal must not give consent to special treatment unless it is satisfied that the treatment is necessary to save the patient's life or to prevent serious damage to the patient's health.

The combined effect of the *Children and Young Persons (Care and Protection) Act 1998* and the *Guardianship Act 1987* is that no person under 16, regardless of competence, nor persons over 16 who are incapable of giving consent, can consent to a non-therapeutic sterilisation. Under this legal framework, it is beyond the scope of parents' or guardians' powers to consent on behalf of a child. Significant penalties of imprisonment for up to 7 years apply to persons who carry out unauthorised sterilisations under both Acts.

Decisions of the Tribunal about sterilisation or termination can be appealed to the Supreme Court of NSW which has the power to review such decisions and to set them aside or to make orders in substitution if it thinks fit.

### WESTERN AUSTRALIA

In Western Australia, there is no specific legislation concerning the sterilisation of children.

At common law, a child is capable of giving informed consent to medical treatment, including therapeutic and non-therapeutic sterilisation, when he or she is sufficiently mature and intelligent to understand fully the implications of the treatment proposed. Where a particular child, whether because of intellectual disability, or simply youth or immaturity, is incapable of giving a valid consent, then his or her parents (or other guardians) are authorised to consent to medical treatment, including therapeutic sterilisation. However, court authorisation is necessary for non-therapeutic sterilisation (*Marion's Case*). The criterion to be applied by a court with the necessary jurisdiction, is whether carrying out the procedure is in the best interests of the child.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The Western Australian *Guardianship and Administration Act 1990* requires that the consent of the State Administrative Tribunal is obtained for an adult with a decision-making disability who lacks capacity to give or refuse consent to sterilisation. A person has a right of appeal to the Supreme Court or Court of Appeal, and sterilisation is not able to proceed until all rights have been exhausted. Following the conclusion of any appeals, the treating doctor must have written consent from both the State Administrative Tribunal and the guardian.

In Western Australian, a therapeutic sterilisation (in very general terms) is a sterilisation which is the incidental result of surgery or treatment appropriately carried out to cure a disease or treat an injury whereas non-therapeutic sterilisation involves surgery or treatment carried out for the purpose of rendering the person infertile.

In relation to adults, the *Guardianship and Administration Act 1990* places limitations on the sterilisation of persons who are under guardianship and lack the capacity to consent to treatment. Under the *Guardianship and Administration Act 1990*, a person is prohibited from carrying out or taking part in any procedure for the sterilisation of a represented person, unless both the guardian and the State Administrative Tribunal have provided written consent to the sterilisation and all rights of appeal have lapsed or have been exhausted. The Tribunal may only consent to the sterilisation of a represented person if it is satisfied that it is in the best interests of that person. In addition to the guardianship provisions, the *Guardianship and Administration Act 1990* also provides that a person responsible (i.e. partner, closest adult relative or friend, or unpaid primary care provider) for a patient who is unable to make reasonable judgments in respect of any treatment proposed, cannot consent to the sterilisation of the patient.

A civil action in trespass and a criminal prosecution for assault may be brought against a health professional if medical treatment is given without consent. However, section 259 of the Western Australian *Criminal Code Act 1913* removes criminal responsibility for the administration in good faith of medical treatment for a person's benefit if the treatment is reasonable, having regard to the person's state at the time and to all the circumstances of the case.

King Edward Memorial Hospital (KEMH) is Western Australia's public tertiary maternity, neonatal and gynaecological hospital. KEMH medical staff follow RANZCOG guidelines and refer cases where appropriate to the State Guardianship Board via the hospital's social work department. These generally include those patients requiring therapeutic sterilisation such as hysterectomy for menorrhagia

The Western Australian Health Hospital Morbidity Data System does not record any cases that are coded as non-therapeutic sterilisation in combination with a disability code. This includes both private and public hospital data.

### QUEENSLAND

In Queensland where a health service or treatment is provided without a person's consent, the provider of the service may be liable to a criminal or civil prosecution. Where an adult has impaired capacity, a comprehensive substitute decision-making regime is established to provide the consent. For special health matters, such as a termination of pregnancy, sterilisation, removal of tissue while the adult is still alive, and participation in special medical research or experimental health care, only a Tribunal may provide consent for such a health matter and only in specified circumstances. These circumstances ensure that the adult's rights and interests are protected.



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

Queensland, like NSW, has an independent expert tribunal and separate legal representation of the child is provided by legal aid at no cost to the child. In Queensland, the Tribunal may consent to sterilisation of a child where:

- it is medically necessary;
- the child is likely to be sexually active and there is no reasonable method of contraception;
- the female child has menstruation problems and sterilisation is the only practicable way of overcoming the problems.

Further, the sterilisation cannot be reasonably postponed and must otherwise be in the child's best interests.

The Queensland medico-legal fraternity is well aware of the precedent set in *Marion's Case*. The requirement for permanent surgical sterilisation to deal with issues of fertility and menstrual problems in women with disabilities has been virtually eliminated by the availability of long acting, reversible implants referred to in the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Guidelines, see page 20.

### SOUTH AUSTRALIA

The South Australian *Guardianship and Administration Act 1993* has provision to approve sterilisations where by reason of their mental incapacity (defined as: inability to look after his or her own health, safety or welfare...as a result of damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration of the brain or mind, or any physical illness or condition that renders the person unable to communicate his or her intentions or wishes) the person is deemed to be unable to make the decision for themselves.

Section 5 of the *Guardianship and Administration Act 1993* allows certain relatives to provide consent for medical or dental treatment, unless the treatment is defined as a 'prescribed treatment,' which is treatment that must not be carried out without the written consent of the South Australian Guardianship Board.

Under the *Guardianship and Administration Act 1993* 'prescribed treatment' includes medical treatments such as sterilisation and termination of pregnancy. In order for the South Australian Guardianship Board to approve 'prescribed treatment' it must satisfy the criteria in section 61.

The criteria include non-therapeutic treatment such as:

- No method of contraception that could ... reasonably be expected to be successfully applied; (Section 61(2)).
- Cessation of her menstrual cycle would be in her best interests (Section 61(2)).

### TASMANIA

The *Guardianship and Administration Act 1995* provides a comprehensive and flexible statutory scheme for the authorisation and approval of medical and dental treatment for persons with a disability who are incapable of giving or refusing consent to treatment. The *Guardianship and Administration Act 1995* gives authority for the 'person responsible', who may be a spouse, carer or close friend of the person unable to give consent, to provide a substitute consent. However, the Guardianship and Administration Board (the Board) must consent to some types of very serious treatments, such as sterilisation.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The *Guardianship and Administration Act 1995* defines sterilisation as ‘any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out’ and makes it a special treatment under section 3. The Board’s jurisdiction to deal with applications to consent to special treatment is provided by sections 44, 45 and 46 of the *Guardianship and Administration Act 1995*. The Board’s jurisdiction usually extends only to adults with disability, however in the area of sterilisation, the Board is the only body who may consent to this treatment for any person with a disability, including minors.

In giving consent, the Board must observe the principles set out in Section 6 of the *Guardianship and Administration Act 1995* which states:

- ‘...a function or power conferred, or duty imposed, by this Act is to be performed so that -
- (c) the means which is the least restrictive of a person’s freedom of decision and action as possible in the circumstances is adopted; and
  - (d) the best interests of a person with a disability or in respect of whom an application is made under this Act are promoted; and
  - (e) the wishes of a person with a disability or in respect of whom an application is made under this Act are, if possible, carried into effect.

Section 45 of the *Guardianship and Administration Act 1995* sets out the following conditions upon which the Board may grant consent:

1. On hearing an application for its consent to the carrying out of medical or dental treatment the Board may consent to the carrying out of the medical or dental treatment if it is satisfied that-
  - (a) the medical or dental treatment is otherwise lawful; and
  - (b) that person is incapable of giving consent; and
  - (c) the medical or dental treatment would be in the best interests of that person.
2. For the purposes of determining whether any medical or dental treatment would be in the best interests of a person to whom this Part applies, matters to be taken into account by the Board include-
  - (a) the wishes of that person, so far as they can be ascertained; and
  - (b) the consequences to that person if the proposed treatment is not carried out; and
  - (c) any alternative treatment available to that person; and
  - (d) whether the proposed treatment can be postponed on the ground that better treatment may become available and whether that person is likely to become capable of consenting to the treatment; and
  - (e) in the case of transplantation of tissue, the relationship between the 2 persons concerned; and
  - (f) any other matters prescribed by the regulations.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### AUSTRALIAN CAPITAL TERRITORY

The ACT Government does not support non-therapeutic, forced sterilisation on young girls and women with disabilities. The Canberra Hospital does, however, recognise the need where these young girls and women become extremely distressed with the management of their menstrual cycle, to implement appropriate medication management that may inhibit or decrease their symptoms related to menstruation, with their consent or their carers' consent.

The ACT *Power of Attorney Act 2006* can appoint power of attorney to make medical decisions in the event that an individual loses capacity. Under this Act, an adult can grant another adult an enduring power of attorney to make decisions for a person with impaired decision-making capacity, as defined by this Act. Individuals to whom a power of attorney has been granted may not exercise power in relation to 'special health care matters'. Special health care matters are defined by Section 37 of this Act to be:

- (a) removal of non-regenerative tissue from the principal while alive for donation to someone else;
- (b) sterilisation of the principal if the principal is, or is reasonably likely to be, fertile;
- (c) termination of the principal's pregnancy;
- (d) participation in medical research or experimental health care;
- (e) treatment for mental illness;
- (f) electroconvulsive therapy or psychiatric surgery;
- (g) health care prescribed by regulation.

If a person cannot give their own consent (i.e. if they have an 'impaired decision making ability') for a prescribed treatment, an ACT Civil and Administrative Tribunal (ACAT) order is required. The law applicable to ACT adult residents unable to provide informed medical consent is the *Guardianship and Management of Property Act 1991*. Under this Act, sterilisations and other matters are referred to as prescribed medical procedures and such medical determinations may only be made by the ACAT. ACAT is required to give consideration to the following:

- (a) the procedure is otherwise lawful; and
- (b) the person is not competent to give consent and is not likely to become competent in the foreseeable future; and
- (c) The procedure would be in the person's best interests; and
- (d) The person, the guardian and any other person whom the ACAT considers should have notice of the proposed procedure are aware of the application for consent.

In addition, for prescribed medical procedures including sterilisation, legislation requires that:

1. The ACAT must appoint the person's guardian, or the public advocate or some other independent person, to represent the person in relation to the hearing relating to the consent.
2. In deciding whether a particular procedure would be in the person's best interests, the matters that the ACAT must take into account include:
  - (a) The wishes of the person, so far as they can be ascertained; and
  - (b) What would happen if it were not carried out; and
  - (c) What alternative treatments are available; and

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

- (d) Whether it can be postponed because better treatments may become available; and
- (e) For a transplantation of tissue-the relationship between the 2 people and other matters.

Compulsory treatment and intervention can only be used when the legislation is satisfied either under the *Crimes Act* or the *Mental Health (Treatment and Care) Act*. Safeguards include criteria-based treatment and intervention, the capacity to review decisions, transparency in decision making, and the statutory requirement for periodic review, procedural fairness mechanisms, and the person to whom the compulsory measures are taken being afforded representation.

Oversight agencies, such as the Public Advocate, also play a role in educating the community about special medical procedures and the legal requirements that must be followed, and about the rights of all girls and women, particularly girls and women who are unable to provide informed medical consent.

### NORTHERN TERRITORY

In the NT sterilisation procedures are governed by two separate systems; one for adults and one for children.

#### ADULTS

NT legislation does allow for sterilisation to be carried out however only in a situation where the consent of the court is obtained.

Section 21(2) of the *Adult Guardianship Act* (NT) provides that a medical practitioner or dentist must not carry out a 'major medical procedure' on a 'represented person' unless the consent of the court has been obtained.

A 'represented person' is an adult in respect of whom an adult guardianship order is in effect. An adult guardianship order is only made under section 15 of the *Adult Guardianship Act* if the court is satisfied the person is under an intellectual disability and in need of an adult guardian.

Medical procedures relating to contraception or the termination of a pregnancy, are defined as 'major medical procedures' under section 21(4)(b) of the *Adult Guardianship Act*.

Section 21(8) of the *Adult Guardianship Act* provides that the court must be satisfied that the sterilisation procedure would be in 'the best interests' of the represented person before making the order. The currently used 'best interest' test is the common law test formulated by the Family Court in *Marion's Case*. Under section 21(8) if the court is satisfied on hearing an application under this section that it would be in the best interest of the represented person, it may, by order, consent to the major medical procedure.

The Court, in considering whether to make an order for a major medical procedure to be undertaken, will take into account the best interests of the adult. The court must also ascertain the wishes of the represented person as far as is reasonably possible (section 21(6)). Section 21(7) of the *Adult Guardianship Act* provides that, subject to section 21(8)- the 'best interest' test, if the court is satisfied that the represented person understands the nature of the proposed major medical procedure and is capable of giving or refusing consent to that procedure, the court shall give effect to the represented person's wishes.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### CHILDREN

Where a child is incapable of giving consent (due to an intellectual disability or immaturity), the NT follows the common law as laid down by the HCA in *Marion's Case*. Only the Family Court may give consent for a child to undergo sterilisation for non-therapeutic purposes (i.e. otherwise than as a by-product of surgery appropriately carried out to treat a malfunction or disease).

### EMERGENCIES

Under the *Emergency Medical Operations Act* (NT) there is no need for authorisation if a medical practitioner believes that waiting for authorisation, to carry out the procedure from the courts, would be harmful to the patient or result in the death of the patient. Similarly the *Adult Guardianship Act* provides that section 21 does not apply in respect of any medical or dental procedure carried out on any person in an emergency where the medical or dental procedure appears necessary to save the life of that person.

It is noted that:

- Section 60 of the *Mental Health and Related Services Act* (NT) prohibits sterilisation as a treatment for those suffering from a mental illness or mental disturbance.
- Section 64 of the *Mental Health and Related Services Act* provides that a major medical procedure cannot be performed on a person who is an involuntary patient or subject to a community management order unless the Mental Health Review Tribunal has given its approval. Separate legal representation is also provided at no cost to a person who appears before the Tribunal.

### 3. PLEASE PROVIDE DETAILS OF ANY ACTIONS TO SANCTION MEDICAL STAFF CARRYING OUT ILLEGAL NON-THERAPEUTIC, FORCED STERILISATIONS OF GIRLS AND WOMEN WITH DISABILITIES, AND WHERE AVAILABLE, THE RESULTS OF ANY INVESTIGATION AND JUDICIAL OR OTHER INQUIRIES CARRIED OUT IN RELATION TO SUCH CASES. IF NO INQUIRIES HAVE BEEN MADE, OR IF THEY HAVE BEEN INCONCLUSIVE, PLEASE EXPLAIN WHY.

The Australian Government is not aware of any recent evidence concerning sterilisations of girls or women with disabilities that have been carried out in contravention of Australian law. Also, the 2006 SCAG review concluded that sterilisations of children with an intellectual disability had declined significantly in Australia since 1997. If such evidence were presented the Australian Government would be very concerned.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### CURRENT AVENUES FOR SANCTION

Under Australian law generally, there are a range of regulations and protections to ensure that medical practitioners are appropriately sanctioned in the event of a medical procedure being carried out in a manner that contravenes the law or disregards the rights of patients

### SANCTIONS OF MEDICAL PRACTITIONERS

Medical practitioners in Australia are required to be registered by the Medical Board of Australia (MBA), in accordance with the *Health Practitioner Regulation National Law Act 2009* (National Law) as adopted in each State or Territory. The MBA is responsible for regulating the practice of the medical profession by registering practitioners, developing professional practice standards, overseeing the assessment of the skills of overseas trained practitioners and managing notifications and complaints against practitioners. The MBA is supported in its role by the Australian Health Practitioner Regulation Agency (AHPRA), an independent statutory agency.

The MBA has issued a code of conduct for doctors in Australia, entitled *Good Medical Practice: A Code of Conduct for Doctors in Australia*. This code articulates the ethical and professional conduct expected of all practitioners and has been developed to be consistent with the *Declaration of Geneva and the International code of Medical Ethics*, issued by the World Medical Association.

Where a medical practitioner's behaviour departs from the code of conduct, the MBA may take action against the practitioner. This action may take the form of cancelling the practitioner's registration, cautioning the practitioner, requiring an undertaking, placing conditions on the practitioner's registration or referring the matter to the health complaints entity in the relevant State or Territory. Where the MBA considers that a practitioner's conduct constitutes professional misconduct, the matter must be referred to a responsible tribunal in the relevant State or Territory. A tribunal may impose a range of sanctions, including suspension or cancellation of the practitioner's registration.

All tribunal outcomes are made available to the public online at:

[<http://www.ahpra.gov.au/Notifications-and-Outcomes/Hearing-Decisions.aspx>](http://www.ahpra.gov.au/Notifications-and-Outcomes/Hearing-Decisions.aspx)

Members of the public may report concerns about a medical practitioner's professional conduct to AHPRA. In addition, other health professionals regulated by the National Law, and employers of medical practitioners, are required to report a reasonable belief that a medical practitioner has placed the public at risk by practising in a way that significantly departs from accepted professional standards. The exception to this is that health professionals in WA are not bound by mandatory notification if the health professional in question is a client or patient, however they may still volunteer the information.

The notification process can be found in full detail online at:

[<http://www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx>](http://www.ahpra.gov.au/Notifications-and-Outcomes/Notification-Process.aspx).



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### MEDICARE AUSTRALIA AND INAPPROPRIATE PRACTICE

The Australian Government's Department of Human Services' (DHS) objective is to make sure payment of Medicare benefits is correctly made for services properly rendered. DHS operates a Health Provider Compliance function. The Health Provider Compliance function is responsible for preventing, detecting and investigating fraud and inappropriate practice.

Health Provider Compliance works with the health industry to:

- ensure the correct benefits are claimed for properly rendered services, and
- prevent and detect fraud and inappropriate practice with respect to claiming of benefits.

Health Provider Compliance applies a balance of education and compliance strategies to meet the requirements for the *Health Insurance Act 1973*, *National Health Act 1953*, and the *Medicare Australia Act 1973*.

If DHS became aware of a claim made for a service that was ineligible for payment of benefits due to an unlawful act, then DHS may take the following actions:

- recover incorrectly paid benefits
- request the Director of Professional Services Review to review the provision of services under Medicare by the practitioner
- refer the matter to Australian Health Practitioner Regulation Agency (AHPRA), and
- refer the matter to the State or Australian Federal police in the relevant jurisdiction.

### STATE AND TERRITORY SANCTIONS

In addition, in each of the States and Territories there are a number of schemes and systems which protect the rights of individuals by imposing sanctions where medical practitioners act inappropriately.

For example, the national Health Practitioner Registration and Accreditation Scheme (which is enacted in Victoria through the *Health Practitioner National Law (Victoria) Act 2009*) provides the means for sanctions against registered health practitioners who act illegally or unprofessionally. The Victorian Government does not know if any procedures involving the sterilisation of girls and women with disabilities have been the subject of investigations or actions by the scheme.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### **4. PLEASE PROVIDE DETAILS OF ANY ACTIONS TO ENSURE THAT REPARATION, INCLUDING COMPENSATION AND REHABILITATION, IS PROVIDED TO THOSE GIRLS AND WOMEN WITH DISABILITIES WHO MAY HAVE BEEN FORCIBLY STERILISED.**

As noted above, Australian Government is not aware of any recent evidence concerning sterilisations of girls or women with disabilities that have been carried out in contravention of Australian law. However, were such allegations to be proven, generally there are a number of avenues for redress under Australian law.

#### **CURRENT AVENUES FOR REDRESS**

Compensation can generally be sought in Australia through four different avenues. Victims can:

- receive a court-ordered payment from an offender as part of a criminal penalty after conviction, or
- issue proceedings for civil damages.

In the current context, under Commonwealth, State and Territory laws there are a range of statutory and common-law criminal and civil offences which deal with unauthorised medical procedures and medical negligence.<sup>5</sup>

In Victoria, for example, the *Guardianship and Administration Act 1986* (VIC) provides quite severe penalties, including up to two years imprisonment and 240 penalty units (one penalty unit is \$122.14), for any medical practitioner who carries out a special procedure without having obtained the proper consent.

At the request of the previous Attorney-General, the Attorney-General's Department is considering options for reform of the Australian legal framework around sterilisation procedures. The creation of sanctions for unauthorised or inappropriate sterilisations, and options for redress girls and women with disabilities who may have been sterilised without their informed consent, or the consent of a court or tribunal, is an issue under consideration. These issues will be raised these issues during discussions with States and Territories.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### **5. PLEASE PROVIDE DETAILS OF ANY ACTIONS TO ENSURE THAT INFORMED CONSENT REQUIREMENTS ARE ADEQUATELY IMPLEMENTED FOR ALL MEDICAL INTERVENTIONS WITH REGARD TO CHILDREN AND PERSONS WITH DISABILITIES.**

#### **INFORMED CONSENT**

There are a number of resources available in Australia to ensure that informed consent requirements are adequately implemented for medical interventions.

The discussions of the HCA in *Marion's Case* regarding the limits of parental authority, consent and medical interventions for children with disabilities have been considered and referenced by judicial officers in both sterilisation and other (non-sterilisation) cases to assist in their assessment of the consent requirements for medical interventions more broadly.<sup>6</sup> In many cases the appointment, at the Court's discretion, of an independent advocate also helps to ensure that the interests of children or adults who cannot provide informed consent are directly represented alongside the wishes of their families or carers.

The States and Territories have also developed statutory frameworks to ensure that an individual's wishes are a primary consideration in decisions made about their health.

In the State of Victoria, for example, the *Guardianship and Administration Act 1986* expressly provides that it is the intent of the Victorian Parliament that any decision or action taken under that Act is the least restrictive of a person's freedom of decision and action; that the best interests of the person are promoted; and the wishes of the person are given effect to wherever possible.

To give effect to these principles Victorian Office of the Public Advocate (OPA) publishes a Practice Guideline to assist OPA staff in dealing with applications for special procedures. The Guideline sets out the legal framework surrounding special procedures and the evidentiary requirements to establish the capacity of the person, the medical need for the procedure, what less restrictive alternatives are available and have been tried, the wishes of the person and what is in their best interests.

In addition, both the Victorian Civil and Administrative Tribunal (VCAT) and OPA as public authorities are required to give proper consideration to and act compatibly with the relevant human rights set out in the *Charter of Human Rights and Responsibilities Act 2006* (VIC). This means when considering applications for special procedures OPA and VCAT must have regard to:

- Recognition and equality before the law as this right deals with discrimination.
- Protection from torture, and cruel, inhuman or degrading treatment as this deals with consent to medical treatment.
- Protection of families may be relevant to a person being able to have a family.
- Right to a fair hearing - ensuring that the person with the disability is properly heard at any hearing about the special procedure.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

A number of Australian governments also produce guidance materials for non-legal practitioners. The Queensland Government for example, publishes *Health Policy Statements* advising medical professionals and the public of their rights and obligations - this includes the operation of informed consent requirements in relation to children and persons with disabilities.<sup>7</sup>

In addition, there is also a wide variety of relevant guidance materials prepared by advisory groups, professional associations and non-government organisations, all of which assist in educating relevant professionals about the informed consent requirements so that they are adequately implemented.

### THE AUSTRALIAN MEDICAL ASSOCIATION (AMA)

As the peak organisation representing the medical profession, the AMA develops policy solutions and provides responses to a broad range of health and medical issues of ongoing importance to Australia. The AMA has produced guidelines on a number of topics that stress the importance of informed consent, including but not limited to the *AMA Code of Ethics - 2004 (Editorially Revised 2006)*, and Guidelines on topics including Informed Financial Consent and Human Genetic Issues.<sup>8</sup>

### GUIDANCE ON STERILISATION

In addition to resources which assist with upholding informed consent requirements generally, there are also a number of resources to assist persons involved in applications for sterilisation.

### THE FAMILY LAW RULES

Guidance for judges in the Family Court can be found in the *Family Law Rules 2004* which make special provision in relation to applications for authorisation of a medical procedure. In particular, Rule 4.09(1) provides that 'if a Medical Procedure Application is filed, evidence must be given to satisfy the court that the proposed medical procedure is in the best interests of the child.'

Further, Rule 4.09(2) requires, under the heading 'Evidence supporting application,' that the evidence a court should consider in such cases:

'...must include evidence from a medical, psychological or other relevant expert witness that establishes the following:

- (a) the exact nature and purpose of the proposed medical procedure;
- (b) the particular condition of the child for which the procedure is required;
- (c) the likely long-term physical, social and psychological effects on the child:
  - i. if the procedure is carried out; and
  - ii. if the procedure is not carried out;
- (d) the nature and degree of any risk to the child from the procedure;
- (e) if alternative and less invasive treatment is available - the reason the procedure is recommended instead of the alternative treatments;

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

- (f) that the procedure is necessary for the welfare of the child;
- (g) if the child is capable of making an informed decision about the procedure -whether the child agrees to the procedure;
- (h) if the child is incapable of making an informed decision about the procedure-that the child:
  - i. is currently incapable of making an informed decision; and
  - ii. is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;
- (i) whether the child's parents or carer agree to the procedure.'

Together with the HCA's decision in *Marion's Case*, these Rules provide guidance as to the factors the Family Court should consider when determining whether it is in the best interests of a child to authorise the performance of a sterilisation procedure on that child.

### THE AUSTRALIAN GUARDIANSHIP AND ADMINISTRATION COUNCIL (AGAC)

The AGAC provides a national forum for State and Territory agencies that protect adults with a decision-making disability through adult guardianship and administration.

In May 2009, the AGAC issued the *Protocol for Special Medical Procedures (Sterilisation)*, which assists the various guardianship tribunals to exercise their decision-making power to promote consistency across jurisdictions when dealing with an application for the sterilisation of a person.

The Protocol, which is periodically reviewed, explains that:

- 1.1 'In all States and Territories of Australia, sterilisation is considered to be such an invasive and irreversible procedure, that where a person cannot give a valid consent to the procedure, an entity such as the Family Court, a state supreme court or guardianship tribunal is the only authority that can provide consent. Further, because of the invasive and irreversible nature of the procedure, the law in all States and Territories provides that, unlike many other medical procedures, a person's normal substitute decision maker for medical and dental treatment cannot make the decision about sterilisation.
- 1.2 For adults with impaired decision-making abilities, consent to the procedure was, and is, given or refused by the State or Territory tribunals that deal with capacity, guardianship and administration issues.
- 1.3 For children, the question of sterilisation is a matter for the Family Court of Australia, however the tribunals of four States also have this jurisdiction.

The Protocol specifically notes that it is intended to assist all persons including 'applicants, potential applicants, relevant professionals and members of the public in understanding the decision-making process and what is required of them in bringing, or objecting to an application to sterilise a person.'<sup>9</sup>

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### RANZCOG GUIDELINES

The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), whose primary role is to train and accredit doctors in the specialities of obstetrics and gynaecology, have produced guidelines on 'Sterilisation procedures for women with an intellectual disability' (C-Gyn 10).

The RANZCOG guidelines state the following:

- In addressing the issues of fertility control for women with an intellectual disability, the least restrictive option and approaches which are similar to those one would consider for women of the same age but without intellectual disability, are the most appropriate.
- Reversible methods such as long acting reversible contraceptive implants (e.g. Implanon or Mirena) should be considered in preference to irreversible surgical options.
- The administration of treatment to a woman with intellectual disabilities must be in accordance with the current law and guardianship provisions of the relevant jurisdictions.<sup>10</sup>

### GUIDANCE ON THE RIGHTS OF PATIENTS

The Australian jurisdictions also have a detailed system that sets out the rights of health care patients regardless of the medical issue they are experiencing.

### THE AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Commission on Safety and Quality in Health Care (the Health Care Commission) identified a need for a national Charter of patient rights in 2007, in order to build trust in the healthcare system and assist the development of mature and balanced relationships between patients and providers based on a shared understanding of their rights and responsibilities. Following extensive consultation, the Health Care Commission developed the *Australian Charter of Healthcare Rights* (the Charter). The Charter was endorsed by Australian Health Ministers in July 2008.<sup>11</sup>

The purpose of the Charter is to provide information about the rights of patients and consumers to underpin the provision of safe and high quality care, and to support a shared understanding of the rights of people receiving care. The Charter applies in all health care settings including public hospitals, general practice and other ambulatory care environments.

Although each State and Territory has existing patient charters, the national Charter addresses jurisdictional variations and is uniformly applicable in all settings in which healthcare is delivered.



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The Charter specifies the key rights of patients and consumers when seeking or receiving health care services. These are: safety, respect, communication, participation, privacy, comment and access. Briefly, the key rights of respect, communication and participation explicitly state that patients have the right to be:

- shown respect, dignity and consideration. The care provided shows respect to the patient, their culture, beliefs, values and personal characteristics
- informed about services, treatment, options and costs in a clear and open way. The patient receives open, timely and appropriate communication about their health care in a way that they can understand, and
- included in decisions and choices about their care.

Under the *National Health Reform Agreement*, signed on 2 August 2011, all States and Territories have agreed the following requirements in relation to patients' rights:

- to prepare and distribute a Public Patients' Hospital Charter (the Charter), in appropriate community languages to users of public hospital services
- to maintain complaints bodies independent of the public hospital system to resolve complaints made by eligible persons about the provision of public hospital services received by them
- to develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non-English speaking backgrounds
- to develop and implement strategies for distributing the Charter to public hospital service users and carers
- to adhere to the Charter
- the Charter will be promoted and made publicly available whenever public hospital services are provided, and
- the Charter will set out a statement of the rights and responsibilities of consumers and public hospitals in the provision of public hospital services in States and the mechanisms available for user participation in public hospital services.<sup>12</sup>

## 6. WHAT MEASURES ARE BEING TAKEN TO ENSURE THE ENJOYMENT OF THE RIGHT TO HEALTH OF GIRLS AND WOMEN WITH DISABILITIES?

The Australian Government has a strong commitment to initiatives that improve the health and wellbeing of people with disabilities, including girls and women, both domestically and internationally. The following initiatives, whilst more broadly targeted at improving the enjoyment of all rights of persons with disabilities, contribute significantly to the enjoyment of the right to health of girls and women with disabilities.

### THE NATIONAL DISABILITY STRATEGY

Australia has developed a comprehensive national action framework that aims to improve the lives of people with disability, promote participation, and create a more inclusive society.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The National Disability Strategy 2010–2020 (the NDS) was launched by the Australian Government on 18 March 2011. This represents the first time in Australia's history that all levels of governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers.

The NDS's ten-year framework will guide public policy across governments and aims to bring about changes to all mainstream services and programs, as well as community infrastructure, to ensure they are accessible and responsive to the needs of people with disability. This change is important to ensure that people with disability have the same opportunities as other Australians – a quality education, good health, economic security, a job where possible, access to buildings and transport, and strong social networks and supports.

The NDS will also be an important mechanism to ensure that the principles underpinning the CRPD are incorporated into policies, services and programs affecting people with disability, their families and carers.

The NDS acknowledges that people with a long-term disability are among the most disadvantaged and invisible groups in our community, with comparatively poor health status and a health system that often fails to meet their needs. This includes people with an intellectual disability, as well as people with other long-term physical and mental conditions, whether present at birth or acquired later in life. These poorer health outcomes include aspects of health that are unrelated to the specific health conditions associated with their disability.

Consequently, one of the central outcomes of the NDS is to ensure that people with disability attain the highest possible health and wellbeing outcomes throughout their lives. The NDS commits to a range of Areas for Future Action designed to achieve this outcome. These action areas focus on:

- improving the interface between disability services and key health services in local communities
- strengthening the continuity and coordination of care
- addressing issues specific to people with disability as part of key national health strategies, such as dental, nutrition, mental health, and sexual and reproductive health programs, and
- ensuring informal and supported decision makers are part of the preventive, diagnostic and treatment programs where appropriate, always ensuring the rights of the individual are respected and protected.

While the NDS aims to improve the lives of all Australians with disability, it recognises that people with disability have specific needs based on their personal circumstances, including the type and level of support required, gender, age, education, sexuality, and ethnic or cultural background. In particular, it recognises that gender can significantly impact on the experience of disability and women and girls with disability often face different challenges by reason of their gender.<sup>13</sup>

### NATIONAL WOMEN'S HEALTH POLICY 2010

The National Women's Health Policy 2010 (the Policy), released in December 2010, aims to provide a framework to improve the health and wellbeing of all women in Australia, especially those at the greatest risk of poor health, through addressing particular health issues, focusing on the social determinants of health inequities and encouraging the health system to be more responsive to women.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The Policy was developed through an extensive consultation process with a wide range of key women organisations, including Women With Disabilities Australia (WWDA), the peak organisation for women with all types of disabilities in Australia.

The Policy identifies women with disabilities as being one of the groups which are at greater risk of poor health as health is determined by a broad range of social, cultural, environmental, economic factors, as well as the genetic and biological factors.

The Policy seeks to understand health within its social context and is based on a gendered approach that is inclusive of a social view of health, and accounts for the diversity in women's experiences. The social model of health acknowledges the complex ways that the context of a woman's life- including her gender, age, socio-economic status, ethnicity, sexuality, disability and geography- might shape her health outcomes; access to health care; experiences of health, wellbeing and illness; and even her death. Addressing these social determinants is a fundamental step towards reducing health inequalities.

### NATIONAL HEALTH REFORM

To ensure that the health system is more responsive to the needs of individuals and local communities, the Australian Government is establishing a coordinating network of primary health care organisations called Medicare Locals. Medicare Locals comprise a major component of the Government's National Health Reform agenda, and are critical to supporting and driving improvements in primary health care for both patients and health care providers.

Medicare Locals will provide all patients with increased access to information regarding services available in their local area and make it easier for patients to navigate their local health care system.

Medicare Locals will support primary health care professionals and organisations to identify and address local health care needs, and improve the delivery of integrated primary health care services.

As they develop, each Medicare Local will develop plans for its particular population and its health needs, including preventive health activities. Primary health care providers will work with Medicare Locals to incorporate women's health into the implementation of initiatives to improve the prevention and management of disease in general practice and primary health care.

The Australian Government also supports women's acute care health services by contributing to the funding of Australia's public hospitals which are administered by the State and Territory Governments. These public hospitals include eleven large hospitals dedicated to the provision of services to women and/or children.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

The reforms, agreed to by the Council of Australian Governments (COAG) in February, were finalised on 2 August 2011. This Agreement will invest an extra \$19.8 billion in public hospitals through to 2019-20, rising to a total extra \$175 billion to 2029-30 matched by tough national standards. In this way, the Agreement will benefit women by funding the provision of better public hospital services, including those delivered by the eleven dedicated women and children's hospitals.

Further opportunities for implementing the *National Women's Health Policy 2010* will be considered in the context of National Health Reform.

### THE NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

On 10 August 2011 the Prime Minister released the Productivity Commission's<sup>14</sup> final report into care and support for people with disability. The Government asked the Productivity Commission to examine reform of disability support services because the Australian Government believes that the system we have today is not delivering the kind of care and support Australians expect for people with disability.

The Productivity Commission has recommended a NDIS that would entitle all Australians to support in the event of significant disability. The Productivity Commission has also recommended a separate National Injury Insurance Scheme (NIIS) to provide no-fault insurance for anyone who suffers a catastrophic injury. The Productivity Commission made clear in its report that there is a lot of work ahead to prepare for a trial of a scheme in 2014.

The Australian Government shares the vision of the Productivity Commission for a system that provides people with disability with the care and support they need over the course of their lifetime. The Commonwealth Government has started work - with States and Territories that are principally responsible for funding and delivering disability support services - to fundamentally reform disability care and support. Work is underway to lay the foundations which are essential for the launch of a National Disability Insurance Scheme. This includes working with the States and Territories to:

- Develop common assessment tools, so people's eligibility for support can be assessed fairly and consistently, based on their level of need.
- Put in place service and quality standards, so that people with disability can expect high quality support irrespective of what disability they have or how they acquired it.
- Build workforce capacity so we have more trained staff to support people with disabilities.<sup>15</sup>

### THE NATIONAL STRATEGY FOR YOUNG AUSTRALIANS

The *National Strategy for Young Australians* sets out the Australian Government's vision for young people 'to grow up safe, healthy, happy and resilient and to have the opportunities and skills they need to learn, work, engage in community life and influence decisions that affect them.' The *National Strategy for Young Australians* will help guide future Australian Government policies and initiatives for young people, including consideration of groups at risk such as young people with a disability, those with mental health issues and young people exiting care.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### SPECIALISED SERVICES

The Commonwealth, State and Territory governments work together to deliver a wide range of specialist disability services for Australians, including girls and women, through the *National Disability Agreement* (NDA).

Under the NDA, the Commonwealth Government has responsibility for employment and income support payments such as Disability Support Pension. Other specialist services are the responsibility of State and Territory governments. Specialist disability services are accessed by Australian women and men on an equal basis, and are based on functional needs rather than diagnosis.

From 1 January 2009 to 30 June 2015, the Commonwealth Government will be providing around \$7.6 billion in funding to the State and Territory governments for increased and improved specialist disability services such as supported accommodation, targeted support and respite. The Agreement means that in 2014-2015, the Commonwealth Government's contribution will be around \$1.4 billion, compared to \$620 million in 2006-07.

### RECOGNITION AND SUPPORT FOR CARERS

The Australian Government recognises the very important role played by Australians who are the carers of girls and women with disabilities. Following public consultation, in August 2011 the Australian Government launched the National Carer Strategy (NCS). The NCS represents the Australian Government's long term commitment to carers. It will guide future reforms, and it builds on reforms the Government is already delivering to better support carers.

There is wide appreciation in the community that the majority of carers who support girls and women with disabilities are women. The Australian Government has adopted several recent initiatives to ensure improved support to carers; and hence to ensure improved enjoyment of the right to health of girls and women with disabilities.

The Australian Government has also recently put in place legislation that formally recognises the role of carers, *Carer Recognition Act 2010*.

### SUPPORT FOR NON-GOVERNMENT ORGANISATIONS FOR PEOPLE WITH DISABILITY

The Australian Government is committed to encouraging participation in and working with non-governmental organisations, peak bodies and associations including those that have a focus on people with disability. These peak bodies represent many types of disabilities, as well as the interests of particular demographic groups of people with disability, for example children and women.

These bodies consult with people with disability and draw on the resources of their member organisations to provide the Australian Government with the perspective of the people with disability they represent. Engagement with these bodies is essential to ensuring that people with disability are consulted and involved in decision-making processes concerning issues relating to people with disability. This includes health issues.

Government support for non-government organisations, whilst more broadly targeted, contributes significantly to the enjoyment of the right to health of girls and women with disabilities.

# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### THE ANNUAL NON-GOVERNMENT ORGANISATION (NGO) FORUM

Recognising the important role played by non-governmental organisations and as part of Australia's Human Rights Framework, an Australian Government NGO Forum on Human Rights is hosted annually by the Commonwealth Attorney-General and the Minister for Foreign Affairs and Trade. The NGO Forum is a key opportunity for comprehensive dialogue on a range of domestic and international human rights issues, including health issues, between the Australian Government and civil society.

### CONSULTATION WITH WOMEN WITH DISABILITIES ON ISSUES THAT AFFECT THEM

The Australian Government provides funds WWDA, the peak body representing women with disabilities in Australia. WWDA is funded to contribute to government policies about disability issues affecting Australian families and communities, to carry information between the Government and the community on social policy issues and to represent the views of its constituents.

WWDA's work is grounded in a human rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. This rights based approach recognises that equal treatment, equal opportunity, and nondiscrimination provide for inclusive opportunities for women and girls with disabilities in society.

WWDA also seeks to create greater awareness among governments and other relevant institutions of their obligations to fulfil, respect, protect and promote human rights and to support and empower women with disabilities, both individually and collectively, to claim their rights.

The Australian Government also funds six National Women's Alliances, which work collaboratively to provide informed and representative advice to government on policy development and implementation relevant to the diverse views and circumstances of women. WWDA is an active member organisation of both the Equality Rights Alliance and the Economic Security for Women Alliance

### STATE AND TERRITORY EXAMPLES OF MEASURES TO ENSURE THE RIGHT TO HEALTH

Provided below is an example of some of the wide range of projects and programs being implemented by State and Territory Governments that also aim to improve the health and wellbeing of people with disabilities, including girls and women. This information is intended to supplement the information about the federal initiatives listed above, and provide a 'case study' of the important work being done by State and Territory Governments to advance and protect the human rights of people with disabilities.



# APPENDIX 3

## RESPONSES FROM THE AUSTRALIAN GOVERNMENT TO THE UNITED NATIONS SPECIAL RAPPORTEURS

### VICTORIA

The Disability Services Division (DSD), of the Victorian Department of Human Services is working to increase the capacity of both the disability service and the family violence sectors to respond to family violence for women with a disability. This includes the *Disability and Family Violence Crisis Response* initiative which will assist women with a disability experiencing family violence who may require immediate disability support to access specialist family violence services while exploring longer term housing and support options. Short term funding will be available to meet immediate needs where required.

In addition, DSD has been working with the Department of Health to improve the outcomes for people with a disability. In particular there has been a focus on strengthening the communication and working relationship between regional Disability Services and Health Services. The aim is to ensure that people with a disability are assisted via pathways to the most suitable forms of health and disability support.

The first Victorian population health survey in relation to people with an intellectual disability report was released in October 2011. This report represents a significant step forward in understanding the health and well being of Victorians with an intellectual disability. Its findings will better inform decisions about the priorities and health interventions aimed at this vulnerable group.

A key finding from the report was that Victorian women with an intellectual disability were less likely to have mammograms and Pap Tests, compared with women in the general population. To address this issue, a grant has been made available to the Cancer Council of Victoria to increase cancer screening participation of women with an intellectual disability.

In addition to these specific programs, there are external organisations that have a role in monitoring disability service providers to protect and promote the rights of people with a disability. They include:

- Victorian Public Advocate, Including the Community Visitors Program.
- Disability Services Commissioner (independent complaints body).
- Office of the Senior Practitioner (monitoring restrictive interventions).
- National abuse and neglect hotline.

# APPENDIX 4

## TERMS OF REFERENCE

On 20 September 2012 the Senate referred the matter of involuntary or coerced sterilisation of people with disabilities in Australia to the Senate Community Affairs Committee for inquiry and report by 24 April 2013.

The **Terms of Reference** for the Inquiry are:

**1. The involuntary or coerced sterilisation of people with disabilities in Australia, including:**

- (a) the types of sterilisation practices that are used, including treatments that prevent menstruation or reproduction, and exclusion or limitation of access to sexual health, contraceptive or family planning services;
- (b) the prevalence of these sterilisation practices and how they are recorded across different state and territory jurisdictions;
- (c) the different legal, regulatory and policy frameworks and practices across the Commonwealth, states and territories, and action to date on the harmonisation of regimes;
- (d) whether current legal, regulatory and policy frameworks provide adequate:
  - (i) steps to determine the wishes of a person with a disability,
  - (ii) steps to determine an individual's capacity to provide free and informed consent,
  - (iii) steps to ensure independent representation in applications for sterilisation procedures where the subject of the application is deemed unable to provide free and informed consent, and
  - (iv) application of a 'best interest test' as it relates to sterilisation and reproductive rights;
- (e) the impacts of sterilisation of people with disabilities;
- (f) Australia's compliance with its international obligations as they apply to sterilisation of people with disabilities;
- (g) the factors that lead to sterilisation procedures being sought by others for people with disabilities, including:
  - (v) the availability and effectiveness of services and programs to support people with disabilities in managing their reproductive and sexual health needs, and whether there are measures in place to ensure that these are available on a non-discriminatory basis,
  - (vi) the availability and effectiveness of educational resources for medical practitioners, guardians, carers and people with a disability around the consequences of sterilisation, and
  - (vii) medical practitioners, guardians and carers' knowledge of and access to services and programs to support people with disabilities in managing their reproductive and sexual health needs; and
- (h) any other related matters.

**2. Current practices and policies relating to the involuntary or coerced sterilisation of intersex people, including:**

- (a) sexual health and reproductive issues; and
- (b) the impacts on intersex people.



# FOOTNOTES

# FOOTNOTES

## APPENDIX FOOTNOTES

- <sup>1</sup> The Text of UPR recommendation P- 86.39 is available online at: [http://www.upr-info.org/IMG/pdf/recommendations\\_to\\_australia\\_2011.pdf](http://www.upr-info.org/IMG/pdf/recommendations_to_australia_2011.pdf)
- <sup>2</sup> 175 CLR 218
- <sup>3</sup> [2010] FamCA 98
- <sup>4</sup> More information on the Victorian Law Reform Commission review of Guardianship is available online at: <http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/Law+Reform/Home/Current+Projects/Guardianship>
- <sup>5</sup> See for example legislation including but not limited to: the *Criminal Code Act 1995* (Cth), the *Civil Liability Act 2002* (NSW), and the *Wrongs Act 1958* (VIC). See also common-law authorities including but not limited to *Rogers v Whitaker* (1992) 175 CLR 479, and *Chappel v Hart* [1998] HCA 55.
- <sup>6</sup> See for example *Re: Baby D (No. 2)* [2011] FamCA 176
- <sup>7</sup> For a copy see the Queensland Health website at <<http://www.health.qld.gov.au/consent/documents/14025.pdf>>.
- <sup>8</sup> For more information see the AMA website- <<http://ama.com.au/>>.
- <sup>9</sup> A copy of the Protocol is available on the AGAC website at: <[http://www.agac.org.au/images/stories/agac\\_sterilisation\\_protocol\\_30\\_mar\\_09.pdf](http://www.agac.org.au/images/stories/agac_sterilisation_protocol_30_mar_09.pdf)>
- <sup>10</sup> A copy of these guidelines is available online at <<http://www.ranzcog.edu.au/publications/statements>>.
- <sup>11</sup> A copy of a supporting document developed by the Health Care Commission outlining the roles and responsibilities under the Charter is at *Attachment 1*.
- <sup>12</sup> *Attachment 2* gives details of Australian and state and territory specific charters of health care rights with specific information in relation to informed consent for care/treatment.
- <sup>13</sup> More information about the NDS is available at: <<http://www.fahcsia.gov.au/saJdisability/progserv/govtint/Pages/nds.aspx>>.
- <sup>14</sup> The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed simply, is to help governments make better policies in the long term interest of the Australian community. More information about the Productivity Commission is available at: <<http://www.pc.gov.au/>>.
- <sup>15</sup> More information about the NDIS and NHS is available at: <<http://www.fahcsia.gov.au/sa/disability/progserv/govtint/Pages/ndis.aspx>>.



Women  
With  
Disabilities  
Australia  
(WWDA)

IN THE COUNTY COURT OF VICTORIA

Revised Not Restricted Suitable for Publication
---

AT MELBOURNE  
CRIMINAL DIVISION

Case No. CR-13-00419

DIRECTOR OF PUBLIC PROSECUTIONS

v

VINOD JOHNNY KUMAR

---

<u>JUDGE:</u>	HER HONOUR JUDGE HAMPEL
<u>WHERE HELD:</u>	Melbourne
<u>DATE OF HEARING:</u>	6 November 2013
<u>DATE OF SENTENCE:</u>	20 November 2013
<u>CASE MAY BE CITED AS:</u>	DPP v Kumar
<u>MEDIUM NEUTRAL CITATION:</u>	[2013] VCC

REASONS FOR SENTENCE

---

Subject:  
Catchwords:  
Legislation Cited:  
Cases Cited:  
Sentence:

---

<u>APPEARANCES:</u>	<u>Counsel</u>	<u>Solicitors</u>
For the DPP	Dr N. Rogers SC	Office of Public Prosecutions
For the Accused	Mr P. Kilduff	Robert Stary Lawyers



HER HONOUR:

1. Vinod Johnny Kumar, on 21 March 2012 you were charged with multiple counts of rape and other sexual offences alleged to have been committed by you on a number of profoundly disabled people who were in your care at supported accommodation provided by Yooralla. You denied those charges. A year later, in March 2013, three days into a contested committal and whilst the third of the complainants was undergoing cross-examination, you instructed your counsel to offer pleas of guilty to all charges. After receiving advice, orally and in writing from your lawyers about the significance and consequences of entering guilty pleas, and signing an acknowledgement you had received and understood that advice, there was no further cross-examination of witnesses, and you entered pleas of guilty to all charges. You were then committed to this court for the matter to proceed by way of guilty plea.
2. On 17 April this year you were arraigned in this court and pleaded guilty to the same charges you had pleaded guilty to at committal, namely eight charges of rape, two of sexual penetration and one of indecent act on a person with a cognitive impairment committed by a worker at a facility designed to meet her needs, and one charge of indecent assault.
3. Four months later on 19 August 2013, you applied for leave before Her Honour Judge Sexton to withdraw your guilty pleas and to proceed to trial on all charges. You gave evidence you pleaded guilty because you thought you would receive a substantially reduced sentence, and as you had since become aware that the sentence was likely to be significantly higher than what you had thought, you wished to proceed to trial. On 18 September 2013, Her Honour Judge Sexton refused the application to withdraw the guilty pleas, and refused your subsequent application for certification, a necessary step if you were to institute an interlocutory appeal to the Court of Appeal. You applied to the Court of Appeal nonetheless for a review of the refusal to certify.
4. Her Honour Judge Sexton's findings of fact were not challenged in the Court of Appeal. Her Honour was satisfied that you had been carefully and properly

advised by your lawyers before the entry of pleas of guilty when committed by the magistrate to this court, and again before being arraigned on the same charges in this court about the effect of entering guilty pleas. She was satisfied on the evidence that your pleas of guilty were unequivocal, and that you understood that by pleading guilty, you were making a true admission of guilt.

5. As the Court of Appeal confirmed, she correctly applied the principles in the High Court decisions of *Meissner*<sup>1</sup> and *Maxwell*,<sup>2</sup> namely that a plea of guilty constitutes an admission of all of the elements of an offence, and that is so whether the plea is entered because of a belief or recognition of guilt, or for other reasons, including to avoid worry, inconvenience, expense, or publicity, to protect family or friends, or in the hope of obtaining a more lenient sentence. Because a plea of guilty is taken to be a true admission of guilt, it will not be set aside unless it could be shown that a miscarriage of justice would occur if it were allowed to stand. Her Honour Judge Sexton found that your belief about the length of the likely sentence to be imposed was a self-induced misconception. Your lawyers had not suggested a sentence of the order that you thought might be imposed. Your belief about the likely length of sentence if you pleaded guilty was based purely on your own supposition, uninfluenced by anything they had said or done.
6. On 18 October 2013 the Court of Appeal, comprising Weinberg and Coghlan JJA and Lasry AJA heard and dismissed your application, holding there was no error in Her Honour Judge Sexton's decision, refusing leave to change your pleas.
7. Her Honour found, correctly as the Court of Appeal held, that a realisation a self-induced belief about the likely length of sentence was wrong did not render your considered decision to plead guilty one which, if allowed to stand, would amount to a miscarriage of justice.
8. The effect of that was to hold you to the guilty pleas that you had entered, and the matter was set down for a plea hearing on 6 November 2013. On that day, you filed an affidavit containing a bald denial of the offences.
9. The prosecution presented a detailed summary of the evidence contained in the depositions in respect of the charges. It was unchallenged by you, save for that

---

<sup>1</sup> *Meissner v R* (1995) 184 CLR 132.

<sup>2</sup> *Maxwell v R* (1996) 184 CLR 501.

bald denial I have referred to.

10. Having taken into account the evidence contained in the depositions, and your affidavit denying the offences, and the materials placed before Her Honour Judge Sexton and the Court of Appeal, I am satisfied beyond reasonable doubt the circumstances of the offending is as set out in the prosecution summary relied upon in the plea hearing.
11. The evidence I accept therefore establishes that the 12 offences to which you had pleaded guilty were committed by you on four people who, because of their severe levels of physical or intellectual impairment, required assistance for the most basic activities of daily living. They all lived in supported accommodation with 24 hour care, provided by Yooralla. Three of your victims lived together in a house which accommodated a total of six residents. The other victim lived in a nearby house which also had six residents.
12. In March 2009 you had begun working on a casual basis for Yooralla as a disability support worker. In August 2011 you were counselled, following two reported instances of inappropriate behaviour. One involved use of inappropriate language to a staff member. The other was more serious, and involved inappropriate, sexualised behaviour with a resident, namely twisting the nipple of a male resident. You were told you would no longer be working at a particular residence, I think the one where that resident lived.
13. Nonetheless, Yooralla continued to employ you as a casual employee. In late 2011, only months after having been counselled, you applied for a permanent position, but according to the prosecution summary, you were unsuccessful because of what was described as “rumours” of inappropriate behaviour with residents and staff. Despite that, it continued to engage you on a casual basis, but working practically full time hours, and you were often rostered on at times when you would be the only support worker at a residence. This, then, is the background I am satisfied of against which the offending occurred.
14. Charges 1 to 4 are all charges of raping a woman who I shall call Ruth.<sup>3</sup> Ruth has cerebral palsy resulting in spastic quadriplegia. She is confined to a motorised wheelchair. She is unable to speak but able to communicate with gestures and

---

<sup>3</sup>

A pseudonym.

spelling out words on her wheelchair tray, although she has trouble controlling her hand to point to the letters. She has some vocalisations that can be slowly understood by those who are familiar with her. She has been assessed as having borderline intellectual capacity and is vision impaired.

15. Ruth requires full assistance with toileting, feeding, showering and other personal care. She requires manual handling and must be hoisted from her bed to her chair. She must also be hoisted into a commode chair for toilet and showering. She was 40 at the time of the offending. All of the acts that I am about to recount occurred when you were the only person on duty in her home. All occurred between October 2011 and mid-January 2012.
16. Between those dates, on each of the occasions you gave Ruth a shower or put her to bed, that is about 20 times, you penetrated her vagina with your fingers. On occasions, you would also touch her breasts. Sometimes you would laugh while you were sexually assaulting her in this manner. You did not wear gloves as you were supposed to when showering a resident. This conduct is relied upon as uncharged acts.
17. In mid-January 2012, you committed the rape the subject of Charge 1. It is a discrete act of digital penetration of Ruth's vagina. On this occasion, Ruth said, it went on for longer, five minutes she estimates, instead of two. You also touched her breasts, laughed, and called her a whore.
18. Charge 2 is rape using an object, a bottle containing hair product, to penetrate Ruth's vagina. You made Ruth lick the bottle before penetrating her with it, and taunted her, saying she would not be able to say what you had done, as well as comparing the size of your penis to the size of the bottle, and speaking of the effect on her were you to penetrate her with your penis. This charge is representative of like conduct occurring approximately ten times.
19. Charge 3 is also a charge of rape using an object. All staff were required to use a pager, which was activated when residents rang the bell by their bed. You put the pager clip in Ruth's vagina and placed the pager between her legs, then made her ring her bell, which caused the pager to vibrate. Again, this charge is representative of like conduct occurring approximately ten times.
20. The final charge again is a discrete act of rape which occurred on the night of the

residents' 2011 Christmas party. You showered Ruth, speaking to her in a sexual way, and then penetrated her vagina with your fingers. She said it was really painful. You told her to stop moving around, when, as you well knew, her movements were involuntary, the product of the cerebral palsy from which she suffers. You told her to behave herself, accused her of acting like a whore, a tart and a slag. You also touched her on her breasts. She told you to stop but you did not.

21. The offending against Ruth stopped in mid-January 2012, about six weeks before you were sacked. Ruth did not tell anyone about it whilst you were employed at her residence because she was scared of you and afraid you might hurt her. She said she thought you would be angry with her if she complained about your conduct. She described you as being aggressive, bossy and a bully.
22. Charges 5 to 8 are all charges of raping a woman who I shall call Jacqueline.<sup>4</sup> Jacqueline suffers from cerebral palsy and is confined to a wheelchair. She has also been diagnosed with depression with psychotic tendencies which emerged in 1993 when she began to hear voices. She has not heard voices for many years. She also suffers from congenital scoliosis of the back and Buerger's disease, a disease involving acute inflammation and thrombosis of the arteries and veins in her feet. Jacqueline requires full time care in the same manner as Ruth. She too was 40. She lived in the same residence as Ruth. Until November 2011 you had not acted improperly towards her. On an occasion in November you made a deeply offensive comment to her, telling her to clean her cunt. She reported you to another staff member. It was after this that the sexual offending against her began.
23. Charge 5 is one of rape by digital penetration. As with Ruth, this occurred when you were showering Jacqueline. You did not wear work gloves as you were supposed to. She said to you "what are you doing? Stop that please". You did not stop instead saying "don't you like this? You know you do". This charge is representative of like conduct on 10 to 12 occasions. Jacqueline said you would often say to her before you penetrated her "you want it, I know you do". You implied she was a prostitute, suggesting she wanted money in return for what you

---

<sup>4</sup>

A pseudonym.

were doing to her. At times you would call her a whore or other pejorative names. She would say to you "please don't do it anymore". You would promise not to do it again, but continued to do so. She said you would often place your hand over her mouth so she could not call out.

24. Jacqueline said that almost every time you were rostered on you would, as she described it, harass her with comments such as "I'm doing a night shift. You won't get much sleep. I'll wake you up and have my way with you all night. I feel horny. I've got something that wants to come and say hello, do you want to see it". You called her names, and caused her deep distress by threatening to put her pet bird on the barbecue. She called it harassment. Properly speaking it is a cruel demonstration to her by you of her powerlessness, subjecting her to debasing and degrading words and conduct, and cruel threats to sexually assault her when you had her at your mercy.
25. Charge 6 is a charge of penile anal rape. On an occasion when you were showering Jacqueline and she was suspended in the hoist, you digitally penetrated her and then attempted to insert your penis into her anus. You moved her to her bedroom and whilst still in the hoist again attempted to insert your penis into her anus. You lowered her into her bed and placed her on her side. She is unable to change position in bed. You again tried to penetrate her anus with your penis and were again unsuccessful. You rolled her over onto her stomach, a position in which she never lies, and this time succeeded in anally penetrating her with your penis.
26. Charge 7 is a charge of penile vaginal rape. It occurred on an occasion when you had put Jacqueline into her bed for the night. You then penetrated her, continuing until you ejaculated. She remonstrated with you, telling you you were hurting her. When you finished you said to her "if you tell anyone about this I could lose my job. If you say anything I'm just going to say that it was consensual the whole way".
27. Charge 8 is a charge of penetrating Jacqueline's mouth with your penis. She needed to go to the toilet. Once the hoist had been used to place her on the toilet she was able to be left alone. She would use her pager to buzz when she had finished. Instead of leaving her alone until she paged you, you entered the toilet on three separate occasions, saying to her "have you finished yet? I'm feeling that



way again. Do you want to see it? It's only you and me here. You'll regret it if you don't". On the third occasion you asked her for oral sex. You pushed your penis into her mouth, and then complained, saying she was biting you. You instructed her to open her mouth wider so you could get it all in. She told you she could not do it anymore but you ignored her, instead forcing her head forward and down onto your penis. When you had finished you simply left her there.

28. Jacqueline remained in the toilet for an hour and a half until your shift finished and the night staff arrived. The following day when you were again on duty she told you that she had stayed in the toilet so long because she did not know what to do, that she did not want you to come and get her off the toilet even though she had finished.
29. Jacqueline did not complain to anyone at the time. She did not think she would be believed as it was her word against yours. She did however say to the team leader on a number of occasions, and to other carers, that she did not want you to assist her, saying that you were rude and bossy.
30. Charges 9 to 11 concern a woman who I shall call Kimberley.<sup>5</sup> Kimberley suffers from cerebral palsy as a result of hypoxic brain injury at birth. She is difficult to understand without the assistance of a person who is familiar with her. Her visuomotor ability is impaired. She suffers from depression and has a history of epilepsy. She has a cognitive impairment such that she falls within the definition of s.50 of the Crimes Act 1958. She also requires full time care in a similar manner to Ruth and Jacqueline. Kimberley was 38.
31. She lived in a different house to the one that Jacqueline and Ruth were in. The acts the subject of these charges occurred on a single occasion, 21 December 2011. You had taken Kimberley to the toilet, pulling her pants down and transferring her to a commode chair which was then placed over the toilet. As was customary she was left there with a towel covering her genitals. She could not wipe herself, and she would call out when she was ready to be wiped, and re-dressed. On this occasion, she called out when she was finished and ready to be assisted out of the toilet. You came in and placed your hand over her mouth and your finger to your lips, telling her to be quiet. You exposed your penis to her and

---

<sup>5</sup>

A pseudonym.

- tried to grab her hand but she pulled away.
32. You then wiped her, but in the course of wiping her bottom you inserted your ungloved finger into her anus. It is that that constitutes Charge 9 of sexual penetration. You then penetrated her vagina with your fingers, saying to her “I know you want to do it”. It is that that constitutes Charge 10 of sexual penetration. You then took Kimberley back to her room and transferred her from the commode chair back to her wheelchair. Her pants were still down. You then stood Kimberly up against you and rubbed her vagina against your jeans. It is this that constitutes Charge 11 of indecent act.
33. Later that day Kimberley needed to go to the toilet again. You took her to the toilet and back to her room when she had finished. Back in her room your hand moved towards her vagina and she said “don’t do that”.
34. About an hour later you came back to her room and apologised for your behaviour. You said “don’t tell anyone about it or my mum will drop dead”. You offered to give her money. She asked you to ring her counsellor. You told her she could tell her counsellor and nobody else. You threatened to come back an hour later and go to bed with her.
35. Kimberley may be intellectually impaired but she knew what you were doing was wrong and she did not want you to touch her. She had pulled her hand away when you first exposed your penis to her and tried to grab her hand. She said that when you penetrated her vagina, that she had wanted to swear at you and tell you to “fuck off”, but it is a measure of her level of cognitive functioning that she felt unable to say that because there was a rule against swearing in the residence.
36. You, however, must have been aware that there was a risk that Kimberley would complain. You told another resident a false story: that you had said something rude to Kimberley, that you were going to apologise to her, and that Kimberly had falsely alleged that you had showed your private parts to her. Kimberley spoke to that same resident later that evening and told him that you had shown your private parts to her and touched her where you should not have. That resident told Kimberley she should tell someone in authority.
37. Meanwhile, you left a note for the team leader at the residence who was due on duty the following morning. You gave a more detailed version of the false story

- you had told Kimberley's co-resident about saying something rude to Kimberley. You alleged that you had apologised to Kimberley but that she had sworn at you, which you said had so upset you that you were unable to concentrate at work. You asked the team leader to call you.
38. The team leader appeared to accept your story, because she immediately went and remonstrated with Kimberley for swearing in breach of the house rules. Kimberley was crying when she went into her room, but the team leader did not ask her why before she remonstrated with her, and told her that her behaviour with a staff member had been inappropriate. It is a measure of Kimberley's strength, or maybe of the impact that your behaviour had had on her, that despite the unfairness of the team leader reprimanding her without first ascertaining her side of the story, that Kimberly immediately responded to the remonstrations by alleging that you had touched her private parts and exposed yourself to her.
39. Unfortunately for Kimberley, the Yooralla response was less than adequate. Kimberley's complaint was described in a client incident report as "a sexual harassment allegation made by Kimberley against casual staff member Johnny Kumar".
40. Kimberley was taken to the police station but when she said she did not want to have a medical examination and did not want to make a statement until she had spoken to her sister she was returned to the residence. These concerns of hers about not being subjected to a medical examination and wanting to speak to her sister before speaking to the police, appear to me to be reasonable concerns given her level of intellectual disability and what she said had happened to her. Although Kimberley's sister was told of the allegations that same day and came that day to see her, it appears no attempt was made to follow up and to take a statement from Kimberley or to launch a formal police complaint or investigation after Kimberley had, as she had wanted to, spoken to her sister. It was not until a report was made to police in respect of other residents that Kimberley's complaint was followed up.
41. Meanwhile, you were stood down and three weeks later attended a meeting with Yooralla senior management. You maintained the false account that you had given your team leader and in fact demanded better support from management

when faced with residents breaching the code of conduct by swearing. Management decided that Kimberly's allegation was not substantiated as you denied it and there were no independent witnesses. You were given a formal warning and allowed to return to work the following day. The warning was not in respect of Kimberley's allegation, but in respect of the way you described your conduct. You apparently had not filled in an incident report properly or reported the matter properly and on your own account you had made an inappropriate comment to Kimberley.

42. You were rostered to work shifts at the residence where Jacqueline and Ruth lived. Two weeks after your return to work, Jacqueline told another carer that she did not want you to shower or toilet her. Ruth then said the same. They both said you were rude and bossy. You were asked to apologise to Jacqueline and Ruth for your rudeness and you did so. Jacqueline in response said "you know why I don't want you to toilet me". She maintained, despite the apology, that she did not want you to bathe or toilet her. It was only after that that the sexual assaults on Jacqueline stopped.
43. It was after the formal warning that I have just referred to following the complaint by Kimberley, and just before Jacqueline made her disclosure, that the event the subject of Charge 12 occurred.
44. Charge 12 concerns a man who I shall call Phillip.<sup>6</sup> Phillip, who was 27 at the time, has cerebral palsy and has an intellectual functioning in the borderline range. He walks with the aid of a walking frame. He has limited ability to speak. He is able to say basic words such as yes, no, and can say greetings and name food items. His speech is unmodulated and loud. He mostly uses a light writer to communicate where he types letters into a machine which then sounds out or speaks out what he has written. Phillip lived in the same residence as Jacqueline and Ruth.
45. In mid-February 2012, Phillip had been out for the day, and when he returned you locked him out of the residence and teased him when he tried to gain admission. Every time he knocked on the door or rang the bell, you would open it and then close it in his face. Eventually you let him in and, as he walked down the hall, you

---

6

A pseudonym.

walked behind him repeatedly pulling his pants down, exposing the top cleft of his buttocks and saying “oh your pants are falling down here they go again”. Philip kept pulling his pants up and trying to get away. This was witnessed by Jacqueline.

46. It was about a month after you had been told to apologise to Jacqueline and Ruth for your rudeness, and about two weeks after you treated Phillip in this way that Jacqueline made a disclosure to people she could trust about what you had done to her.
47. Coincidentally, at the same time you made some inappropriate comments about the residents and a staff member to a co-worker. Amongst other things you described the residents as “easy” and volunteered to this co-worker that you had put your pager between Ruth’s legs. Still nothing was done to investigate or to protect the residents.
48. Matters came to a head a short time later when the staff member about whom you had made an inappropriate comment to a co-worker complained about your sexual harassment of her. Consistently with the manner in which you had sought to pre-empt matters after Kimberley had remonstrated with you for sexually assaulting her, you gave notice, stating as your reason unhappiness about the way you were being treated.
49. It was not until your resignation became effective that further disclosures were made by the residents to other Yooralla staff and it was following that that the police were contacted and a formal investigation commenced.
50. On 21 March 2012, about a month after your resignation, you were arrested and interviewed. You denied any wrongdoing in that interview and in the further interview that was conducted with you in August 2012 following the receipt of further complaints by the police about your conduct.
51. Victim impact statements were provided by all four victims. Philip used his lightbox to read his victim impact statement himself. In doing so he provided a very powerful indication of how vulnerable he and the other complainants were. Each of them articulated in their victim impact statements that they knew that what you were doing was wrong, and that they did not want to be touched and abused by you in the way they were. They were unable, by reason of their disability, to

escape, and unable, by reason of their disability, to vocalise their lack of consent, or to call for help. However their disabilities did not extend to a failure to appreciate that what you were doing was wrong. Each of them in their own way articulated the sense of violation and powerlessness they felt, and each expressed the same range of responses that we in the courts are only too used to hearing from victims of sexual assault: anger, shame, guilt, fear and powerlessness. As Dr Rogers said in the course of the plea, each of your victims were trapped within their own bodies.

52. This is offending of the greatest order and greatest gravity. It was a gross breach of trust. You were employed as a carer for these people whose vulnerability was increased because of the physical and intellectual disabilities they suffered. They were powerless to defend themselves or to physically remonstrate with you. So far as the charges of penile penetration are concerned, there is the added aggravating feature that you did not use a condom.
53. This was not opportunistic or spontaneous offending. Except perhaps in the case of Philip, it was clear that you were careful to choose your time and place, when you were the only person on duty and when your three female victims were at their most vulnerable. The offending against them occurred in the bathroom where they were dependent upon you for toileting, or at least for assistance onto and off the toilet, or in their bedrooms where again they were dependent upon you because they could not move without assistance.
54. The objective gravity of your offending is very high. The language you used to all three female victims as you sexually assaulted them was disparaging, degrading and belittling, and indicates a serious disrespect for their dignity, their rights and their autonomy. It is impossible on the materials before me to know whether it is indicative of a more pervasive misogyny, or was confined to a contemptuous disrespect for these three profoundly disabled women.
55. Although the offending so far as Philip is concerned may have been more spontaneous, it was also very cruel. He was, because of his limited mobility and his need to use a walking frame, unable to get away from you or to stop you doing what you did. That you did it to him in public in front of somebody else clearly added to the sense of humiliation and powerlessness.



56. It is clear therefore that, subject to considerations personal to you, denunciation, deterrence both general and specific, and protection of the community are significant sentencing considerations in determining what is the just punishment for this offending. No civilised community can countenance such abuse of the disabled for whom the whole community has a responsibility to care. Disabled people are entitled to have their dignity respected, to feel safe in their homes and safe with those who are entrusted with their care. The people who have had to take responsibility for making the decisions to place them in care, or to assist the disabled people to make such a decision, should be able to trust that they are safe and that they will be safe in care. The parents, families and friends of your disabled victims and of disabled people generally should be able to feel that they are safe and will be treated at all times with dignity and respect. Those who breach that trust in the manner that you have must understand that their conduct will be condemned, and that they will be sternly punished.
57. Dealing then with matters personal to you. You are 31, and first arrived in Australia in early 2007, aged 25. By the end of that year you had completed a Certificate IV in English and a Diploma in Community Welfare Work. After a short return to India, you came back to Australia in 2008. In March 2009 you began working at Yooralla on a casual basis. You continued to be employed by Yooralla until you resigned in February 2012. Following your arrest in March 2012 you have been remanded in custody. Since your remand it has been discovered that your visa had expired. Your right to remain in Australia is therefore uncertain, and I am told you have expressed a desire to return to India on the expiration of your sentence.
58. You have no other convictions in this country. As your counsel acknowledged, it was in part the absence of convictions which enabled you to obtain the employment which you exploited so shamelessly and, in the circumstances, past good character or evidence of it by absence of previous convictions does not carry as much weight as it may in other cases.
59. You told your counsel Mr Kilduff that you were born in the Punjab in India to a wealthy family, sent to a boarding school at the age of six, and had almost no contact with your family for the next ten years. You said that you had misbehaved

at school, and as punishment your father made you stay at school during the holidays. I was told you then spent a year in the cadets, which you enjoyed, and where you excelled at shooting, before being recruited at the age of 16 into an elite secret military force, where you remained for a year. You reported you wanted to train as a fighter pilot, but that your father insisted you undertake a homeopathic medicine course in New Delhi. You completed that course in four years and at the age of 21 were ordered to return to military service. You reported you were posted to Kashmir, where you narrowly escaped death when a landmine blew up. At the age of 25, I was told, you were dismissed after you were court martialled following an incident where you shot some terrorists.

60. I was told you had met a young woman when studying in New Delhi, who you wanted to marry. She too, you said, came from a wealthy family, but her parents did not approve of your marriage. Whilst you were in military service, she was diagnosed with leukaemia and, if I understood correctly, that apparently brought the relationship to an end. After your military service ended, your father arranged a marriage for you, but you refused to accept the bride chosen for you. As a result, your father disowned you and it was then that you came to Australia.
61. After obtaining your diploma in 2007, you returned to India for two weeks before returning to Australia and have been here ever since. In June 2012, after your remand in custody, your parents and brother were murdered in India by a sniper. You believe it was a case of mistaken identity and that you were the actual target. The only family therefore left in India is a sister.
62. I have no way of knowing whether this quite remarkable account of your circumstances is a truthful one. If true, you have had little experience of family life or family relationships, and have little family support to call on. Nothing was put to suggest that any of this bears on the assessment of your moral culpability, or on the weight to be given to deterrence, or, save for the matters that I have mentioned - that is, lack of family support - to hardship in custody.
63. I must sentence you therefore on the basis that you are a 31 year old man born overseas with no family or friends here and little family support in India to fall back on. Imprisonment will be more onerous for you than for a person who is supported by family and friends.

64. Your pleas of guilty have utilitarian value and I reduce the sentence otherwise appropriate on that basis. As your counsel acknowledged, the pleas do not in the circumstances provide evidence of remorse, and there is no other evidence before me indicating remorse.
65. As was acknowledged, the seriousness of the offences calls for a substantial term of imprisonment. In determining the appropriate sentences for each charge, I have imposed higher sentences for the representative charges. The charges concerning Kimberley carry a lesser maximum than those concerning Ruth and Jacqueline. They are bad examples of their type, and so bear a proportionately higher relationship to the maximum sentence than do the sentences I have fixed for the charges concerning Ruth and Jacqueline. Although each of the charges concerning Kimberley occurred as part of a single episode, there should in my view be a degree of cumulation between them because of the discrete acts involved. The sentence for the charge concerning Philip reflects its less invasive but nonetheless degrading nature. I have sought to impose periods of partial cumulation which reflects the totality of the offending concerning each victim, and reflects the totality of the overall criminality.
66. Although I know nothing of your reasons for committing these offences and no material has been put before me which bears on the risk of reoffending or your prospects for rehabilitation, I will fix a non-parole period which will allow for the prospect of supervised release at a time when those matters may be better able to be assessed.
67. You come to be sentenced as a serious sexual offender in respect of Charges 3 to 12. I accept the prosecution submission it is not necessary to impose a disproportionate sentence to achieve the paramount sentencing consideration of protection of the community that flows from that serious sexual offender declaration.
68. Can you now please stand.
69. Vinod Johnny Kumar, on the 12 charges to which you have pleaded guilty, you are convicted.
70. On Charge 1, you are sentenced to be imprisoned for a period of six years. On Charge 2, you are sentenced to be imprisoned for a period of eight years. On

Charge 3, you are sentenced to be imprisoned for a period of eight years. On Charge 4, you are sentenced to be imprisoned for a period of six years. On Charge 5, you are sentenced to be imprisoned for a period of eight years. On Charge 6, you are sentenced to be imprisoned for a period of six years. On Charge 7, you are sentenced to be imprisoned for a period of six years. On Charge 8, you are sentenced to be imprisoned for a period of six years. On Charge 9, you are sentenced to be imprisoned for a period of five years. On Charge 10, you are sentenced to be imprisoned for a period of five years. On Charge 11, you are sentenced to be imprisoned for a period of two years and six months.

On Charge 12, you are sentenced to be imprisoned for a period of one year.

71. I declare that the sentence on Charge 2 of eight years is the base sentence and I make the following cumulation orders. On Charge 1, six months cumulative upon the base sentence and the other partial cumulation orders. Charge 3, one year. Charge 4, six months. Charge 5, three years and six months. Charge 6, six months. Charge 7, six months. Charge 8, six months. Charge 9, one year. Charge 10, one year. Charge 11, six months. Charge 12, six months. That makes a total effective sentence of 18 years and I fix a period of 15 years as the time you must serve before being eligible for parole.

72. I declare pursuant to s.6AAA of the Sentencing Act, that but for your pleas of guilty, I would have sentenced you to be imprisoned for a period of 24 years and I would have fixed a period of 21 years as the time that you would have had to have served before being eligible for parole.

73. I declare that you have spent 609 days in pre-sentence detention and direct that that be reckoned as part of the sentence already served.

74. Pursuant to the *Sex Offender Registration Act 2004*, the nature of these offences requires to report for life.

75. I have been asked to make a forensic sample order and I propose to do so. That requires you to make that by way of provision of a buccal sample. That requires you to provide a sample from a rubbing on the inside of your mouth. If you do not cooperate in the provision of that sample, then the police are authorised to use reasonable force and it is at least likely that they will use the more invasive method

of obtaining that sample, namely the taking of a blood sample. Do you understand that?

76.OFFENDER: Yes.

77.HER HONOUR: I have been asked to make a disposal order in respect of the hair product bottle and I will make that order. I am required to have the reporting conditions under the Sex Offender Registration Act provided to you and I will ask my associate to give those reporting conditions now to Mr Kilduff and for him to give them to you. You are asked to sign a receipt acknowledging that you have received those reporting conditions. You are not required to sign the receipt. The court record will note in any event that you have been given the notice of reporting conditions. Whilst that is being done, Dr Rogers, can you check the arithmetic and make sure that it is correct?

78.MR KILDUFF: I have checked mine, Your Honour - - -

79.HER HONOUR: You have checked the arithmetic and that is - you are satisfied it is correct?

80.MR KILDUFF: Yes.

81.HER HONOUR: Thank you, Mr Kilduff.

82.DR ROGERS: I have checked that and it appears to be correct.

83.HER HONOUR: Thank you. You are actually required to leave those reporting conditions with him, not take them yourself.

84.MR KILDUFF: I was going to take them down to him, Your Honour? I was going to go and see him after this.

85.HER HONOUR: My understanding under the Act is that I have got to make sure they are physically handed to him in my presence.

86.MR KILDUFF: I will do that, Your Honour.

87.HER HONOUR: Thank you. I note that the receipt has been signed. Any further orders?

88.COUNSEL No, Your Honour.

89.HER HONOUR: Thank you. Remove Mr Kumar please.

90. - - -

STOP THE VIOLENCE

# REPORT OF THE PROCEEDINGS AND OUTCOMES

NATIONAL SYMPOSIUM ON  
VIOLENCE AGAINST WOMEN  
AND GIRLS WITH DISABILITIES

SYDNEY, AUSTRALIA  
25 OCTOBER 2013



Women  
With  
Disabilities  
Australia  
(WWDA)





Women  
With  
Disabilities  
Australia  
(WWDA)

**WOMEN WITH DISABILITIES  
AUSTRALIA (WWDA)**

PO BOX 605 ROSNY PARK  
TASMANIA 7018 AUSTRALIA

**T** +61 (3) 6244 8288

**F** +61 (3) 6244 8255

**E** [wwda@wwda.org.au](mailto:wwda@wwda.org.au)



people with disability

**PEOPLE WITH DISABILITY  
AUSTRALIA (PWDA)**

52 PITT ST REDFERN  
NSW 2016 AUSTRALIA

**T** +61 (2) 9370 3100

**F** +61 (2) 9318 1372

**E** [stvp@pwd.org.au](mailto:stvp@pwd.org.au)



**THE UNIVERSITY OF  
NEW SOUTH WALES (UNSW)**

SYDNEY  
NSW 2052 AUSTRALIA

**T** +61 (2) 9385 2608

**F** +61 (2) 9385 1040

**E** [stvp@unsw.edu.au](mailto:stvp@unsw.edu.au)



# CONTENTS

ABBREVIATIONS	4
INTRODUCTION	5
MESSAGE FROM THE PRIME MINISTER, THE HON TONY ABBOTT MP	6
OPENING ADDRESS BY THE HON MICHAELIA CASH, MINISTER ASSISTING THE PRIME MINISTER FOR WOMEN	7
INTRODUCTORY REMARKS BY MS ELIZABETH BRODERICK, PROJECT STEERING GROUP CHAIR AND SEX DISCRIMINATION COMMISSIONER, AUSTRALIAN HUMAN RIGHTS COMMISSION	11
MESSAGE FROM MS KARIN SWIFT, PRESIDENT OF WOMEN WITH DISABILITIES AUSTRALIA	13
PROCEEDINGS OF THE NATIONAL SYMPOSIUM	16
Program	17
Plenary 1: Key Issues in Violence and Women and Girls with Disabilities	18
Plenary 2: Challenges and Opportunities for Change	19
Working Group Sessions	21
OUTCOMES OF THE NATIONAL SYMPOSIUM: FUTURE DIRECTIONS	22
Area 1: Information, Education and Capacity Building for Women and Girls with Disabilities	22
Area 2: Awareness Raising for the Broader Community	23
Area 3: Education and Training for Service Providers	24
Area 4: Service Sector Development and Reform	25
Area 5: Legislation, National Agreements and Policy Frameworks	26
Area 6: Evidence Gathering, Research and Development	27
Area 7: Establishment and Development of the Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities	28
Area 8: Establishment of a National Women with Disabilities Expert Panel on the Prevention of Violence Against Women and Girls with Disabilities	30
APPENDICES	31
Communiqué from the National Symposium.....	31
About the Stop The Violence Project	34
National Symposium Attendees	35

## ABBREVIATIONS

<b>AHRC</b>	<u>Australian Human Rights Commission</u>
<b>AHRC</b>	<u>Australian Human Rights Commission</u>
<b>CALD</b>	<u>Culturally and Linguistically Diverse</u>
<b>CEDAW</b>	<u>Convention on the Elimination of Discrimination Against Women</u>
<b>COAG</b>	<u>Council of Australian Governments</u>
<b>CSW</b>	<u>Commission on the Status of Women</u>
<b>ECG</b>	<u>Expert Consultative Group</u>
<b>EDAC</b>	<u>Ethnic Disability Advocacy Centre</u>
<b>LGBTQI</b>	<u>Lesbian, Gay, Bisexual, Transgendered, Queer and Inter-sex</u>
<b>NCAS</b>	<u>National Community Attitudes Survey</u>
<b>NCE</b>	<u>National Centre of Excellence</u>
<b>NDIS</b>	<u>National Disability Insurance Scheme</u>
<b>NDISRG</b>	<u>National Disability Insurance Scheme Reference Group</u>
<b>NDS</b>	<u>National Disability Services</u>
<b>NPIP</b>	<u>National Plan Implementation Plan</u>
<b>PIC</b>	<u>Project Implementation Committee</u>
<b>PSG</b>	<u>Project Steering Group</u>
<b>PSS</b>	<u>Personal Safety Survey</u>
<b>PWDA</b>	<u>People with Disability Australia</u>
<b>STVP</b>	<u>Stop the Violence Project</u>
<b>UNSW</b>	<u>University of New South Wales</u>
<b>WWDA</b>	<u>Women With Disabilities Australia</u>

## INTRODUCTION

The one-day National Symposium on Violence against Women and Girls with Disabilities was held at the Australian Human Rights Commission, Sydney on Friday 25 October 2013. The National Symposium was part of the activities of the Stop the Violence Project (STVP) funded by the Australian Government Department of Social Services and implemented by Women With Disabilities Australia (WWDA).

The purpose of the National Symposium was to engage high-level stakeholders and decision-makers to address issues of violence against women and girls with disabilities in Australia in order to develop measures for longer term sustainability for change relating to the National Plan to Reduce Violence against Women and their Children, 2010-2022. The National Symposium sought to foster collaborative approaches to policy development by strengthening cross-sector relationships and leadership for sustaining change in the identification and implementation of better practice models to prevent violence against women and girls with disabilities.

The aims of the National Symposium were:

- to raise awareness of the issue of violence against women and girls with disabilities;
- to engage high level stakeholders and decision-makers in moving forward to address violence against women and girls with disabilities;
- to discuss issues identified by the evidence gathering exercise for the STVP;
- to promote, canvass and consult on good policy and practice measures and models;
- to promote cross-sector collaborative relationships for systems integration;
- to share information on what works and what doesn't work; and
- to provide leadership for sustaining change in the identification and implementation of better practice models of policy, program, service system development and responses which will prevent violence against women and girls with disabilities.

The National Symposium provided an interactive forum for exchange of ideas and information on key thematic areas and mechanisms for preventing and addressing violence against women and girls with disabilities in Australia.



PRIME MINISTER

## MESSAGE FROM THE PRIME MINISTER STOP THE VIOLENCE NATIONAL SYMPOSIUM

Violence against women and girls is utterly unacceptable. It is unacceptable in Australia and unacceptable across the world.

The Stop the Violence National Symposium is confronting the serious issue of violence against women and girls. In particular it will focus on confronting violence against women and girls with disabilities.

The Symposium is also promoting the National Plan to Reduce Violence against Women and their Children.

I am working with my colleague and Minister Assisting for Women, Senator the Hon Michaelia Cash, to ensure the National Plan is implemented, is effective and supports our most vulnerable.

I congratulate Women With Disabilities Australia, People With Disability Australia and the University of New South Wales for your work on the Stop the Violence Project and for organising this event.

I send my best wishes for a successful event.

The Hon Tony Abbott MP  
Prime Minister of Australia

22 October 2013



## OPENING ADDRESS BY **THE HON MICHAELIA CASH**

MINISTER ASSISTING THE PRIME MINISTER FOR WOMEN

Ladies and gentlemen, friends, all - Good morning. It is an honour to be here on behalf of the Prime Minister to give the opening address to the 'Stop The Violence' National Symposium.

Donna, thank you for your welcome to country. I too would like to acknowledge the traditional owners on whose land we meet today, the Gadigal people, and pay my respects to their Elders past and present.

May I commence by acknowledging our special guests here today. The first is a dear friend of mine, Liz Broderick. Liz, what can I say about you other than you are amazing. You are a true champion of women's rights, and you are also a true champion in relation to stopping the violence against women and children and in particular, against women and children with disabilities. I think the fact that so many people are here today is a testament of exactly what you have achieved.

To Karin Swift, President of Women with Disabilities Australia, I am humbled by your on-going championing of the reduction of violence, in particular, in relation to women and children with disabilities. As part of the Australian delegation to the Commission on the Status of Women, earlier this year, you were one of the stand-out figures who made a huge difference, with your presence, and with what you said - Thank you Karin.

And of course, a man who does not need any introduction because he is so fantastic in this area, our Disability Discrimination Commissioner - Mr Graeme Innes - who has literally spent his life dedicated to advocating for people with disabilities, but in particular, in relation to women with disabilities. Graeme it is always fantastic to be in the same room as you. It is so good to see you.

Can I also make a very special mention of each and every one of you who have given up your time to be here today.

Carolyn said to me earlier, *'Michaelia we've got a really, really special group of people here today. They are people who are so committed to this cause that they are not just here to listen. This is a hand-picked group who are going to get down and do a lot of work today, and make sure that at the end of this National Symposium you have some fantastic policy ideas to bring back to Government.'* So, congratulations to each and every one of you. It's a recognition of your work and dedication that you have been chosen to be here today.

Ladies and gentlemen, violence against women and girls with disabilities is a serious issue. We all know that it is a basic right for women and girls to feel safe in all aspects of their lives. We all know, however, that the unfortunate truth still is, and the statistics tell us, that one in three women don't experience that basic right that so many of us take for granted.

There is the woman who dreads every weekend, waiting for her husband's alcohol-fuelled rage to drive her and her children into hiding in different parts of the house, wondering if and when they are going to be able to come out.

There is the pregnant woman who doesn't know when her boyfriend is next going to punch her.

There is the woman who is wheel-chair bound and if she falls from her chair her husband doesn't tell her carers, he doesn't take her to the doctor or the hospital and he doesn't get her checked.

There is the woman who has a disability as a direct result of her abuse. At just sixteen years old her boyfriend almost bashed her to death by repeatedly stomping and kicking her head. He beat her so badly she suffered a severe brain injury and was in in a coma for four months.

The bad news about those stories is that I didn't make them up for today. As you all know, they are real-life situations that I am merely relating to you, but which highlight why this national symposium is so very, very important. Each of those women has a different experience. The stories are different. But there is one common thread that links each and every one of those stories, and that is that those stories are completely, totally and utterly, in 2013, unacceptable.

The firm commitment of Tony Abbott our Prime Minister, and our Government, is that it is not acceptable for violence against women and children to be secreted away behind closed doors.

Violence against women must be acknowledged.

Violence against women must be addressed.

Violence against women must be eliminated.

Ladies and gentlemen, in relation to the Abbott Government's commitment in this area, it is a long-held passion of the Prime Minister, his wife Margie, and myself, that we work towards eliminating violence against women and children.

The Coalition Government's long term commitment in this area was evidenced under the former Howard Government. Many of you would know from working with the former Howard Government, we committed \$75.7 million dollars to the Women's Safety Agenda and you would remember it addressed four main priority themes.

In particular, we became a world leader in relation to the Women's Safety Agenda, with the 'Violence Against Women - Australia Says No' campaign. That really did put this particular cause front and centre in the minds of all Australians. It sent an unequivocal message to the community, and one which I really hope you have been able to build on: that violence against women and girls, and violence generally, in society, is unacceptable. We are back in government, and my pledge to you is that we will now build on what previous Coalition governments have done in this space.

I can personally assure you that you have a true champion in Prime Minister, Tony Abbott. He is dedicated to improving the lives of women and girls. That's a statement that I can stand up here and make. If I was you I would be saying 'Well hold on Michaelia. What do you have to actually back up that statement?' Well, let me tell you. Many people don't know that in his private life he has been a long-time supporter of The Manly Women's Centre in his electorate of Warringah.

Many of you would have heard about the 'Pollie Pedal' that our Prime Minister sets off on every year. Whilst yes, he is a dedicated cyclist and he loves every minute of this, there is a reason he actually does the 'Pollie Pedal'. It's his way of raising funds for charity - he and group of dedicated politicians have raised a lot of money for The Manly Women's Shelter. They have raised in excess of \$350,000 over the years and I'm proud to say that Margie Abbott is a formal patron of the Manly Women's Shelter. I hope this gives you some indication that it is a life-long dedication of our PM to just quietly go about ensuring that there are resources for these types of places.

In relation to the National Plan, many of you whom I had the opportunity of meeting with when I was the Shadow Parliamentary Secretary would know that I am 110 per cent committed to the implementation of the National Plan.

We are now at the end of the first phase of the National Plan. I am very excited that it is a Coalition Government that is going to be given the opportunity of launching phase two of the National Plan next year. We have made some great progress under phase one. However, there is still work to do. The Prime Minister and I are committed to working with each and every one of you to ensure that the next phase of the National Plan ensures that we take a step-up in reducing violence against women and children.

One of the areas that I am personally passionate about, and have spoken with the Prime Minister in terms of 'where do you want to see a coalition government going?' is very much in the area of primary prevention.



We all know the statistics in relation to the violence against women and children, it costs our economy \$13.6 billion dollars a year, and according to all of the analysis if we don't do something about it that figure is only going to rise. We all know the shocking statistics of violence against women and if we truly want to address this we really need to start looking at a real focus on primary prevention.

The White Ribbon Day Parliamentary Breakfast at Parliament House, which I hope to see some of you at, does a fantastic job in ensuring that people understand that women's problems are men's problems as well. Men are unfortunately, more often than not, the perpetrators of violence against women. It's wonderful to see so many men here today, because it means that you are truly committed to ensuring that this is something that stops.

In relation to White Ribbon, I was very proud that one of our election commitments is an additional 1 million dollars to The White Ribbon Campaign over four years. We believe that this is much-needed funding that will ensure that they can continue with their very, very targeted approach to ensuring that men understand it is not acceptable to be a perpetrator of violence, but also, to work with those thousands of men who have taken the pledge.

Our Prime Minister Tony Abbott took the pledge some time ago. The pledge, as he said: 'We cannot rest until we entirely eliminate violence against women. Violence is never, ever acceptable as a way of settling disputes. It is particularly unacceptable when it is employed against people who are inherently vulnerable.'

And, as we all know this a message that each Australian, but in particular, each boy and girl in Australia needs to grow up understanding. It's only when you convince the next generation that violence is unacceptable, that we will have true cultural change, and we will be so many steps closer to ensuring that we live in a society where violence against women and children is eliminated.

In relation to evidence building, I am a believer, as you all are, in evidence-based policy. The Coalition will be proudly supporting The National Centre of Excellence, which is now up and running, and in fact our Foreign Minister Julie Bishop, highlighted the NCE at a meeting with the US Secretary of State, John Kerry, just a few weeks after the election. We look forward to working with the team at the NCE to ensure that the current gap between research and practical steps is brought together, and I think that's a great step forward.

We are all here today to recognise the very particular needs of women with disabilities who experience violence. It's a fact, we all know it, that women with disabilities are more vulnerable to violence than other women. Many women with a disability face additional problems in accessing appropriate support, and we all know the reality is that fewer have the option of escaping violence.

We also hear, very disappointingly, of too many stories of violence within supported care and residential care facilities. Again, completely, totally and utterly unacceptable.

Karin, I know you did a great job, as I said earlier, in relation to CSW in New York earlier this year, and I know that it was because of your efforts that this topic was something that was spoken about at an international level by Australia and by an Australian delegate in Karin, and I truly believe that this has well and truly raised the profile of this internationally. So again, well done Karin!

I want to assure you that the Government is very proud of the work that each and every one of you do in the non-governmental sector to ensure that there is a reduction, and hopefully eventually, a complete elimination of violence against women and children, and in particular, violence against women with disabilities.

I don't underestimate how hard it is for each and every one of you, as it is always the way in this space, there is always a limited pool of resources, but please don't underestimate the work you do. Please don't underestimate the value of that work for us as your politicians, when formulating policy that will make a real difference in the lives of effected women.



In closing I would like to read, a message from the Prime Minister, who could not be with us today.

*'Violence against women and girls is utterly unacceptable. It is unacceptable in Australia and unacceptable across the world.*

*The Stop the Violence National Symposium is confronting the serious issue of violence against women and girls. In particular it will focus on confronting violence against women and girls with disabilities.*

*The Symposium is also promoting the National Plan to Reduce Violence against Women and their Children.*

*I am working with my colleague and Minister Assisting for Women, Senator the Hon Michaelia Cash, to ensure the National Plan is implemented, is effective and supports our most vulnerable.*

*I congratulate Women With Disabilities Australia, People With Disability Australia and the University of New South Wales for your work on the Stop the Violence Project and for organising this event.*

*I send my best wishes for a successful event.'*

And on that note again, it is an honour and it is a privilege for me to be here today and to have been given this very, very humbling opportunity to open your conference. Enjoy the day.



## INTRODUCTORY REMARKS BY **MS ELIZABETH BRODERICK**

**PROJECT STEERING GROUP CHAIR AND SEX DISCRIMINATION COMMISSIONER,  
AUSTRALIAN HUMAN RIGHTS COMMISSION**

Thank you so much, Senator Cash for coming along today, for showing such deep commitment to the work that is happening here. Just like you, all of us here feel deeply about combating violence against women with disabilities. It is great to have your support and the Prime Minister's support for the initiatives, the evidence gathering and the sharing of best practice that will happen throughout the day today, and I really look forward to continuing to work with you over the next period on these really important issues.

I want to acknowledge the Traditional Owners of the land we are meeting on, the Gadigal people of the Eora Nationa and pay my respects to their Elders past and present.

I wish to also acknowledge the Assistant Minister for Social Services, Senator Mitch Fifield, who sends his sincere apologies and best wishes for the event. I know from his work, while in opposition, that he is a strong supporter of strategies to ensure that people with disability, and particularly women and girls can enjoy the same rights as everyone else and I know Graeme Innes would support me in saying what a strong supporter he is in this particular area because as we know women and girls with disability face considerable discrimination and violence across all regions of the world, not just here in Australia. It was really brought home to me just in the last couple of weeks when I went to the World Bank. I sit on their Gender Advisory Board and we have been looking once again at the key issue of violence against women and girls and particularly women with disabilities. I was interested to learn that violence against women and girls is at epidemic levels across the world today. For the first time the number of women and girls living with violence is higher than the number of malnourished people in the world. So, most importantly, also at the global level, it is identified that violence against women and girls is probably the major impediment to them contributing fully to society, to improvements in society and improvements in our economy.

So we deeply care about the human rights case here today. But if that is not enough to get you over the line, the fact is that all women should have the right to contribute fully to a positive society – a society that benefits everyone and, indeed, a vibrant and strong economy.

That is the main message, and the message that we will hear today, and that is why it is so important to take the violence out of the private sphere and put it right up on the public agenda. That is what we are doing today; by understanding the evidence base, by actually starting to get the hard data out into the public sphere we can debate it, we can deliberate and share about leading strategies to take this forward.

The Committee on the Rights of Persons with Disability in its recent review of Australia, recommended in its Concluding Observations that "Australia include a more comprehensive consideration of women with disabilities in public programs and policies on the prevention of gender based violence, particularly so as to ensure access for women with disabilities to an effective integrated response system". I think that is what we found in the work that we have done and the discussions that we have had up until now. There is good work being done, but it is done in pockets, and we need to bring that together, and we need to ensure that it is part of the mainstream service delivery response in Australia for women affected by violence.

The National Plan to Reduce Violence against Women and their Children recognises that. The National Plan focuses on primary prevention. It is great to hear the Minister talk about a focus on primary prevention. But the National Plan also recognises that women and girls with disabilities experience higher levels of domestic and family violence and sexual assault, that they have high levels of unmet needs in terms of access to

domestic violence and sexual assault services and related community support services. Further, increasing the community's understanding of the complexity and nature of these issue and how they play out for women with disabilities is also very important. So what we need is some targeted measures to ensure that women with disabilities can participate fully and equally in Australian society, that they can enjoy their human rights to the same extent as everyone else.

The Stop the Violence Project is overseen by Women With Disabilities Australia, People with Disability Australia and University of New South Wales.

In particular I want to acknowledge Karin and Carolyn and all the amazing women from WWDA who are here today and I have to absolutely agree with the Minister. It is so wonderful when I go into CSW each year and I travel with representatives from WWDA, just what powerful advocates you are on the global stage. It is Australia that has helped put these issues on the global agenda and I feel so very proud about that.

Therese Sands of People with Disability Australia who is here with us has done such great work from that organisation. Also, the University of New South Wales has done an amazing job in gathering the evidence, in developing the survey and engaging with stakeholders and making sure that today the right people are in the room.

As Chair of the Steering Group, I want to welcome you all to the Symposium today. I feel very honoured to be a part of this and I know that this is just the beginning of the conversation and action that will take place. Today we will come together, we will share the best practice, we will collaborate across sectors and identify measures for reform. And I look forward to engaging in that discussion with everyone today.



## MESSAGE FROM **MS KARIN SWIFT**

### PRESIDENT OF WOMEN WITH DISABILITIES AUSTRALIA

I would like to start by reminding you that Australia is a Member State of the United Nations. Our country is a signatory to seven core international treaties and several other instruments that create clear obligations in relation to gender equality and disability rights. By signing and ratifying these international agreements, Australia has committed to take all measures, including targeted, gender-specific measures to ensure that women and girls with disabilities can realise and experience their rights and freedoms. However, let us be very clear: Australia has failed to ensure women and girls with disabilities benefit from these provisions and commitments. Instead, systemic prejudice, discrimination, apathy and indifference continues to result in widespread denial, and violation of, our most basic rights and freedoms – including our right to live free from violence.

Although we experience many of the same forms of violence that all women experience, when gender and disability intersect, violence has unique causes, takes on unique forms and results in unique consequences.<sup>1</sup> We also experience forms of violence that are particular to our situation of social disadvantage, cultural devaluation and increased dependency on others. Poverty, race, ethnicity, religion, language and other identity status or life experiences can further increase our risk of violence.<sup>2</sup> Compared to non-disabled women, we experience violence at significantly

higher rates, more frequently, for longer, in more ways, and by more perpetrators, yet policies, programs and services for us either do not exist, are extremely limited, or simply just exclude us.<sup>3</sup>

We experience alarmingly high rates of multiple forms of violence from a range of perpetrators, including physical, psychological and sexual violence; financial abuse, neglect, social isolation, entrapment, degradation, trafficking, detention, forced sterilisation and psychiatric treatment, forced contraception and forced abortion, denial of health care, including exclusion from sexual and reproductive health care services, to name just a few.<sup>4</sup>

We are twice as likely to experience domestic/family violence as non-disabled women, are likely to experience this violence over a longer period of time and suffer more serious injuries as a result.<sup>5</sup> We are raped and sexually assaulted at a rate of at least two times greater than other women.<sup>6</sup> More than 70 per cent of us have been victims of violent sexual encounters at some time in our lives.<sup>7</sup> More than a quarter of rape cases reported by females in Australia are perpetrated against women with disabilities.<sup>8</sup> And it is estimated that between 50 - 70 per cent of women with psychosocial disabilities in Australia have experienced past physical or sexual abuse, including child sexual assault.<sup>9</sup> For example, a recent Victorian study

- 
- 1 Frohmader, C. & Ortoleva, S. (2013) *The Sexual and Reproductive Rights of Women and Girls with Disabilities: Issues Paper.*, Prepared for the ICPD Beyond 14 International Conference on Human Rights, The Hague, Available online at: [http://www.wwda.org.au/issues\\_paper\\_srr\\_women\\_and\\_girls\\_with\\_disabilities\\_final.pdf](http://www.wwda.org.au/issues_paper_srr_women_and_girls_with_disabilities_final.pdf).
  - 2 Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper.* Hobart: Women with Disabilities Australia.
  - 3 Frohmader, C. (2011) *Submission to the UN Analytical Study on Violence against Women and Girls with Disabilities*, Prepared for Women With Disabilities Australia (WWDA), <http://www.wwda.org.au/WWDASubUNStudyViolenceWWDDec2011.pdf>.
  - 4 Frohmader, C. & Ortoleva, S. (2013) OpCit., International Network of Women with Disabilities (2011) *Violence Against Women with Disabilities*. Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities, Center for Women Policy Studies.
  - 5 National Council to Reduce Violence against Women and their Children, 'Background Paper to Time For Action: The National Council's Plan for Australia to Reduce Violence Against Women and their Children, 2009–2021' (Background Paper, Department of Families, Housing, Community Services and Indigenous Affairs, March 2009).
  - 6 See for eg: United Nations General Assembly (2012) *Thematic study on the issue of violence against women and girls and disability. Report of the Office of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/20/5; See also: WWDA (2007b) 'Forgotten Sisters - A global review of violence against women with disabilities', WWDA, Rosny Park, Tasmania.
  - 7 Stimpson & Best; cited in Elman, A. (2005) *Confronting the Sexual Abuse of Women with Disabilities*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence.
  - 8 See for eg: Reported from Victorian study in Frohmader, C. (2011) OpCit.



found that 45 per cent of women in psychiatric hospitals had been sexually assaulted, 67 per cent had been sexually harassed and 85 per cent felt unsafe.<sup>10</sup>

Women and girls with disabilities who live in institutions experience, and are at significant risk of violence. For many, violence is a day to day reality of their lives and frequently involves sustained and multiple episodes. Yet violence perpetrated against women and girls with disabilities in institutions is rarely characterised as domestic violence and rarely are domestic violence related interventions deployed to deal with this type of violence.<sup>11</sup>

For many women with disabilities in Australia, identification and recognition that violence in their lives is a problem or a crime remains a significant issue. They may have difficulties in recognising, defining and describing the violence; have limited awareness of strategies to prevent and manage it; and lack the confidence to seek help and support. Those who do seek support often find themselves on a referral roundabout without ever finding a pathway to safety.<sup>12</sup> Many women with disabilities remain in violent and abusive relationships and environments simply because they have no other option.

Typically, most women with disabilities do not report the violence perpetrated against them. We often lack access to legal protection, and law enforcement officials and the legal community are ill-equipped to address the violence. Our testimony is often not viewed as credible by the courts; and we are not privy to the same information available to non-disabled women. The lack of appropriate, available, accessible and affordable services, programs and support is a major factor that increases and contributes to violence against us.

Successive Australian Governments have conceded that violence against women with disabilities in Australia is 'widespread'; that we are extraordinarily vulnerable to violence and abuse, and that we experience significant barriers in accessing services and support. Yet violence against women and girls with disabilities still remains largely outside the public debate and policy responses to violence against women. We therefore urge the newly elected Abbott Government to take up the recommendations from the Committee on the Rights of Persons with Disabilities without delay, and we look forward to engaging with the Government on their implementation.

The primary response to addressing violence against women in Australia, including women with disabilities, is through the twelve year *National Plan to Reduce Violence against Women and their Children 2010-2022*, and its National and Jurisdictional Implementation Plans. However, in relation to addressing violence against women and girls with disabilities, the National Plan has limitations, in that there is little emphasis on girls with disabilities, it focuses only on domestic/family violence and sexual assault and fails to address the multiple forms of violence that women and girls with disabilities experience. In addition, although Aboriginal and Torres Strait Islander women are included in the National Plan and other mainstream strategies, there are no clear provisions which address violence and abuse of Aboriginal and Torres Strait Islander women with disabilities, and this remains an unaddressed area of public policy and service provision. A similar situation exists for culturally and linguistically diverse (CALD) women with disabilities.

The *Stop the Violence Project* (STVP), which has brought us together here today, is a positive first step in laying the groundwork for improved service

9 Victorian Women and Mental Health Network, 'Nowhere to be Safe: Women's Experiences of Mixed-Sex Psychiatric Wards' (Report, April 2008) pp. 4-5.

10 Victorian Mental Illness Awareness Council, *Zero Tolerance for Sexual Assault: A Safe Admission for Women* (2013).

11 Frohmader, C. & Swift, K. (2012) Opening minds & opening doors: Reconceptualising 'domestic violence' to be inclusive of women with disabilities in institutions. *CDFVRe@der*, Vol. 11, No. 2, pp. 7-8. Available at: <http://www.noviolence.com.au/public/reader/readerdec2012.pdf>.

12 Dowse, L. et al. OpCit.

provision for women and girls with disabilities who are experiencing, or at risk of violence. It is one of a number of projects funded by the Commonwealth Government under the *National Plan to Reduce Violence Against Women and their Children 2010-2022* (National Plan). The STVP is overseen by Women With Disabilities Australia (WWDA), the peak non-government organisation for women with all types of disabilities in Australia and implemented in conjunction with the University of New South Wales and People with Disabilities Australia.

The STVP emerged from WWDA's long standing commitment to addressing one of the most pressing issues for its membership: violence against women and girls with disabilities in Australia. The objective of the STVP is to identify structural issues to improve service responses to women and girls with disabilities experiencing or at risk of domestic and family violence. It investigates and identifies gaps and good practice models for improvement of services. Through stakeholder engagement, consultations and a nation-wide survey, the project lays the groundwork for improved service provision by building an evidence base for future reforms so that the service system is more responsive to the needs of women and girls with disabilities who are affected by violence. The evidence gathered from the STVP are presented and discussed at the National Symposium.

The challenge however, will be to ensure that this initiative is adequately resourced and sustained through the life of the National Plan. We must now ensure implementation, coordination and monitoring of the key reforms the STVP has identified, and further develop initiatives that address the multiple forms of violence that women and girls with disabilities experience.

I would like to take this opportunity as President of WWDA, to pay tribute to our CEO, Carolyn Frohmader, who for more than 16 years has worked tirelessly to promote the rights of women and girls with disabilities, particularly their right to bodily integrity and to live free from violence, exploitation and abuse. It would be remiss of me as WWDA President, not to publicly state that WWDA is an organisation of only one paid employee – Carolyn – and we carry out our critically acclaimed work nationally and internationally on a total operating budget of only \$163,000 per year. I thank Carolyn for the dedication, commitment and incredibly long hours she has worked over many years to advance the rights and freedoms of women and girls with disabilities.

Thank you and I hope that we can all engage with the process and work together with us to Stop the Violence.



## PROCEEDINGS OF THE NATIONAL SYMPOSIUM

The Stop the Violence National Symposium on Violence against Women and Girls with Disabilities was held on Friday 25 October 2013 at the Australian Human Rights Commission in Sydney. The National Symposium was attended by 58 participants including women with disabilities, key stakeholders and decision makers in the government and non-government sector, as well as experts and academics working in the field of disability and violence against women.

The National Symposium, the first of its kind to be conducted in Australia, was designed to foster active participation and discussions to identify good policy and practice measures for reform across different sectors so that women and girls with disabilities can escape violence and be able to live with dignity and respect, participating fully and equally in Australian society.

The National Symposium consisted of two plenary and panel discussion sessions followed by eight simultaneous working group discussions which addressed key emerging issues and mechanisms for directing good policy and practice emerging from the project followed by presentations and discussions at a plenary session. These issues, as set out in the *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Discussion Paper* included:

- Information, Education and Capacity Building for Women and Girls with Disabilities;
- Awareness Raising for the Broader Community;
- Education and Training for Service Providers;
- Service Sector Development and Reform;
- Legislation, National Agreements and Policy Frameworks;
- Evidence Gathering, Research and Development;
- Establishment and Development of the Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities; and
- Establishment of a National Expert Panel on the Prevention of Violence Against Women and Girls with Disabilities;

Further information about the National Symposium, including the *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper*, the *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Discussion Paper*, presentation podcasts and transcripts and including this Report of Proceedings and Outcomes are available on the STVP website [www.stvp.org.au](http://www.stvp.org.au)



## PROGRAM

### FRIDAY 25 OCTOBER 2013

TIME	SESSION
9:30am	<b>Registration</b>
10:00am	<b>Welcome to the country</b> Ms Donna Ingram, Metropolitan Local Aboriginal Land Council
10:05am	<b>Opening Address</b> Senator the Hon Michaelia Cash, Minister Assisting the Prime Minister for Women
10:20am	<b>Introductory Remarks and Goals for the Day</b> Ms Elizabeth Broderick, Project Steering Group Chair and Sex Discrimination Commissioner, AHRC
10:25am	<b>Plenary 1: Key Issues in Violence and Women &amp; Girls with Disabilities</b> Chair: Ms Elizabeth Broderick, PSG Chair & Sex Discrimination Commissioner, AHRC Introduction to the Issue: Ms Karin Swift, President, WWDA
10:35am	<b>Panel Discussion:</b> Ms Gayle Rankin, Chairperson, First Peoples Disability Network, South Australia Ms Nihal Iscel, Ethnic Disability Advocacy Centre, Western Australia Ms Janice Slattery, Member, Reinforce Self-Advocacy, Victoria Ms Margie Charlesworth, Vice-President, WWDA
10:55am	<b>Discussion from the floor</b>
11:10am	<b>Break</b>
11:30am	<b>Plenary 2: Challenges and Opportunities for Change</b> Chair: Mr Graeme Innes, Disability Discrimination Commissioner, AHRC Introduction to the Issues: Mr Graeme Innes, Disability Discrimination Commissioner, AHRC
11:40am	<b>Panel Discussion:</b> Ms Debbie Kilroy, CEO, Sisters Inside Dr Gabrielle Drake, Lecturer, University of Western Sydney Dr Leanne Dowse, Senior Researcher STVP, University of New South Wales
12:00pm	<b>Discussion from the floor</b>
12:15pm	<b>Lunch</b>
1:00pm	<b>Working Group Session</b> Group 1: Information, Education and Capacity Building for Women and Girls with Disabilities Group 2: Awareness Raising for the Broader Community Group 3: Education and Training for Service Providers Group 4: Service Sector Development and Reform Group 5: Legislation, National Agreements and Policy Frameworks Group 6: Evidence Gathering, Research and Development Group 7: Establishment and Development of the Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities Group 8: Establishment of a National Expert Panel on the Prevention of Violence Against Women and Girls with Disabilities
2:15pm	<b>Break</b>
2:25pm	<b>Plenary: Feedback from Groups</b>
4:10pm	<b>Summary</b>
4:25pm	<b>Communiqué from the Symposium</b> Ms Therese Sands, PWDA
4:35pm	<b>Closing Remarks</b> Ms Elizabeth Broderick, Project Steering Group Chair and Sex Discrimination Commissioner, AHRC
4:45pm	<b>Close</b>

## PLENARY 1

### KEY ISSUES IN VIOLENCE AND WOMEN AND GIRLS WITH DISABILITIES

#### ELIZABETH BRODERICK – CHAIR

Sex Discrimination Commissioner of the Australian Human Rights Commission chaired the first panel discussion of the National Symposium on key issues in violence against women and girls with disabilities.

#### KARIN SWIFT – INTRODUCTION TO THE ISSUES

The President of WWDA, Karen provided an introduction to the issues of violence against women and girls with disabilities in Australia. Karin highlighted the systemic prejudices, discrimination, apathy and indifference which continue to result in widespread denial and violation of basic rights and freedoms of women and girls with disabilities to live free from violence. She explained that women and girls with disabilities experienced alarmingly high rates of multiple forms of violence from a range of perpetrators, including physical, psychological and sexual violence; financial abuse, neglect, social isolation, entrapment, degradation, trafficking, detention, forced sterilisation and psychiatric treatment, forced contraception and forced abortion, denial of health care, including exclusion from sexual and reproductive health care services. Karin expressed regret at Australia's failure to ensure that women and girls with disabilities benefit from the provisions and commitments of international treaties and instruments that their country it is party to, and called on the Government to implement adequately resourced and sustained initiatives that address the multiple forms of violence that women and girls with disabilities experience.

#### PANEL DISCUSSION

**Gayle Rankine**, a Ngarrindjeri woman from South Australia, Gayle is the Chairperson of First Peoples Disability Network (Australia). Gayle's presentation highlighted her personal experiences of violence and her regret that violence is a norm in Australian society in 2013. She identified the need to educate men on issues of violence against women in order for men to understand and acknowledge that it is not culturally acceptable to perpetrate violence against women and girls. Also of concern Gayle cited high rates of sexual abuse within institutions and the lack of support networks in remote communities across Australia.

**Nihal Iscel** is the Manager of Advocacy Services at the Ethnic Disability Advocacy Centre (EDAC) in Western Australia. Nihal explained that many women with disabilities from non-English speaking backgrounds experiencing violence encountered barriers in accessing services due to language issues and lack of knowledge of available services. Nihal identified that in some cultural contexts disability is perceived negatively and women with disabilities are devalued, resulting in their exploitation. She highlighted the need for increased awareness among women and girls with disabilities from CALD communities about resources and services that could assist them to escape from violence and exploitation. She called on the Government to provide additional resources to address this need.

**Janice Slattery** is from Reinforce self-advocacy group in Melbourne and describes herself as a wife, self-advocate, and a woman with an intellectual disability. Janice highlighted her own personal experiences and the long time it took for people to accept that a woman with an intellectual disability can be a strong, independent person, able to take care of herself. She explained that society often viewed such women as exploitable and emphasised the need for advocacy so that the community viewed women with intellectual disabilities also as people having equal rights.

**Margie Charlesworth** is Vice-President of WWDA. Her presentation highlighted the ways women with communication disabilities are stripped of their legal capacity and denied justice on the basis that if their words are unclear they should not be trusted. Margie called for the development of mechanisms that can enable women and girls with communication issues to have equal access to the justice system and equal recognition before the law. She also highlighted the need to educate women and girls with communication difficulties in ways to realise their rights, to have their voices heard and their rights upheld.

## DISCUSSION

The presentations from the panel members were followed by clarifications, comments and discussions from the floor which highlighted:

- the lack of data collection on violence against women with disabilities in Indigenous communities; and
- the issue of foetal alcohol spectrum disorder (FASD) and the complexities it raised to recognition as a disability, and its impacts on mothers.

## PLENARY 2 CHALLENGES AND OPPORTUNITIES FOR CHANGE

### GRAEME INNES – CHAIR AND INTRODUCTION TO THE ISSUES

Disability Discrimination Commissioner of the Australian Human Rights Commission chaired the second panel discussion and provided an introduction on the challenges and opportunities for change, outlining the gaps in the current legislative, policy and service frameworks that impact on violence prevention and response for women and girls with disabilities. He explained that these gaps arise because the intersection between gender and disability is generally not taken into account in legislative and policy frameworks, and because legislative and policy frameworks generally lack a human rights context in relation to the human rights treaties ratified by Australia. This effectively meant that violence prevention and response strategies are piecemeal, inconsistent and often did not include protections and responses for women and girls with disabilities. Graeme also suggested that, as had been discussed in the Access to Justice consultations, the use of different definitions of what constitutes 'violence' across different jurisdictions, and the focus of the Disability Service Standards and the NDIS Act on 'abuse and neglect' rather than 'violence,' tended to minimise the severity of crimes perpetrated against people with disabilities and trivialised serious crimes to 'administrative infringements' or 'management issues'.

**Debbie Kilroy** is a former prisoner and the CEO of Sisters Inside - an independent community organisation in Brisbane that advocates for the human rights of criminalised women. Debbie's presentation highlighted the systemic violence experienced by women in prisons and in residential care facilities. She suggested that law and policy alone cannot address violence against women as often laws designed to protect women also lead to their increased arrests, based on their

'reactive violence' to domestic abuse situations. This results in a false picture in data that seem to suggest that women are becoming more violent. She also spoke about the difficulties faced by women with disabilities within the prison system as they are not allowed access to their carers.

**Gabrielle Drake** is a lecturer in Social Work at the University of Western Sydney. In her presentation, Gabrielle highlighted the challenges faced by women with disabilities who live in boarding houses and psychiatric institutions. She highlighted that some women with disabilities prefer to live on the streets rather than face the violence and intimidation experienced in some boarding houses. Gabrielle also explained the need for researchers to address definitions of 'homelessness' and 'houselessness' in Australia and emphasised the importance of allowing women with disabilities to set the research agenda and for other researchers to work as co-researchers to identify targeted strategies to stop violence against women with disabilities.

**Leanne Dowse** is an academic and researcher in Social Research and Policy at the University of New South Wales and leader of the Stop the Violence Project team at UNSW. Leanne's presentation outlined the evidence gathering process for the STVP and highlighted that this was the first of its kind in Australia. Leanne suggested that given the high response rate to the national survey from across all jurisdictions and sectors, it provides findings that are representative and significant nationally. The evidence suggests a lack of a common, shared understanding of good policy and practice service provision to address issues of violence against women and girls with disabilities. She also highlighted the six key areas that were identified through the research as requiring attention, including recognising violence, responding to violence, inclusion and participation of women with disabilities, sector development, cross-sector collaboration and data capture and use. Leanne also explained that even though there are pockets of good policy and practice, overall it appears that there is an inadequate service response in Australia to issues of violence against women and girls with disabilities.

## DISCUSSION

The presentations from the panel members were followed by questions and discussions from the floor. The discussions centred on:

- structural and systemic barriers which women with disabilities face, particularly around pursuing appropriate opportunities and action for redress;
- increased susceptibility to violence due to confluence of disability discrimination, stigmatisation and exclusion;
- additional issues women with disabilities face due to housing inaccessibility, relationships of support within varying housing arrangements such as supported housing and accommodation, group homes, boarding houses, etc.; homelessness and much more; and
- the role of the National Disability Insurance Scheme and the development of mechanisms within the scheme to recognise the high degree of susceptibility to violence from a range of parties for women with disabilities.

## WORKING GROUP SESSIONS

The participants of the National Symposium were pre-assigned to eight Working Groups, representing eight key areas for enhancing good policy and practice emerging from the evidence base gathered for the Stop the Violence Project. The eight areas were:

- Group 1** Information, Education and Capacity Building for Women and Girls with Disabilities
- Group 2** Awareness Raising for the Broader Community
- Group 3** Education and Training for Service Providers
- Group 4** Service Sector Development and Reform
- Group 5** Legislation, National Agreements and Policy Frameworks
- Group 6** Evidence Gathering, Research and Development
- Group 7** Establishing and Development of a Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities
- Group 8** Establishment of a National Expert Panel on the Prevention of Violence Against Women and Girls with Disabilities.

The Working Group discussions were moderated by a Chair assigned to each group, who was assisted by a scribe to capture the discussions and agreed final statements from the groups. Each group presented their suggested discussions and recommendations for action to the Symposium for discussion and agreement.

The focus of the National Symposium was on the outcomes of the research, so not all aspects of the very rich discussions in the Working Groups could be incorporated into key areas for action for this report. This discussion demonstrated the enthusiasm of participants to engage fully with and offer feedback on the materials. The discussions provided one of the first opportunities for a very diverse group of experts to come together to discuss issues relevant to violence against women and girls with disabilities.

The following section presents the Principles/ Mechanisms, Strategies and Possible Areas of Action identified and debated by the Working Groups and agreed to in the Symposium summary discussion.

## OUTCOMES OF THE NATIONAL SYMPOSIUM

### FUTURE DIRECTIONS

A synthesis of the survey findings, consultations with women with disabilities, research literature and legislative and policy mapping resulted in six key thematic areas plus two possible future mechanisms to support the development of good policy and the provision of good practice in service provision to address and prevent violence against women and girls with disabilities.

#### AREA 1 INFORMATION, EDUCATION AND CAPACITY BUILDING FOR WOMEN AND GIRLS WITH DISABILITIES

##### PRINCIPLE

Commonwealth, State/Territory and Local governments provide enabling environments so that women and girls with disabilities are empowered to identify, disclose, substantiate and escape from violence.

##### STRATEGIES

- 1.A Women and girls with disabilities are provided support to be informed and educated, within a human rights framework, to recognise violence perpetrated against them, including the types and extent of this violence.
- 1.B Women with disabilities and their organisations, groups and networks are supported to promote appropriate policy and practice responses to all forms of violence perpetrated against them across relevant health, human and justice contexts.
- 1.C In addition to mainstream supports, specific support and information addresses education and capacity

building for particularly at risk groups including Indigenous women with disabilities; CALD women with disabilities; women with disabilities who reside in congregate settings, including supported accommodation, mental health facilities, disability and aged-care facilities and correctional settings.

- 1.D Current disability services policy and the National Disability Insurance Scheme (NDIS) as it is progressively introduced, identifies violence against women and girls with disabilities as a priority at the level of individual service provider organisations.
- 1.E Women and girls with disabilities take part in relevant human rights forums as UN delegates.

##### POSSIBLE AREAS OF ACTION

- 1.1 Provide human rights education and training for women and girls with disabilities at national, state/territory, regional and local levels so that women and girls with disabilities are informed and educated to recognise what constitutes violence, including the types and extent of violence perpetrated against them.
- 1.2 Develop capacity of individuals and of disabled women's organisations, groups and networks to address all forms of violence perpetrated against them. This could be achieved through a National Women With Disabilities Grants Program that provides funding for activities that respond to the particular needs and circumstances of women and girls with disabilities and ensure participation at all levels of decision making and at all stages of the designing, implementation, monitoring and evaluation of policies, programs and services affecting women and girls with disabilities.



- 1.3 Build the capacity of WWDA by reviewing and increasing annual funding (\$168,000) provided by the Australian Government including staffing levels (1 EFT).
- 1.4 Develop specific information, education and capacity building strategies for Indigenous women with disabilities, CALD women with disabilities, and women with disabilities in institutions.
- 1.5 A national database of accessible crisis accommodation services is developed, which details levels of accessibility for women with disabilities, (and/or women with children with disabilities) experiencing or at risk of violence.
- 1.6 The National Centre for Excellence includes representation of women with disabilities on its governance and advisory structures.
- 1.7 Representative organisations are supported and resourced on an ongoing formal basis to provide delegates with information and material to assist women with disabilities undertaking systemic advocacy work within Australia and internationally.

## AREA 2 AWARENESS RAISING FOR THE BROADER COMMUNITY

### PRINCIPLE

The rights of all women and girls with disabilities to live free from violence and the fear of violence in all aspects of their lives are understood by the broader community.

### STRATEGIES

- 2.A Universal, targeted and sustained community campaigns raise awareness of the rights of women and girls with disabilities, and are conducted to prevent violence against women and girls with disabilities before it occurs.
- 2.B Awareness campaigns to highlight that perpetration of violence against women and girls with disabilities is a crime and to incorporate information on pathways to safety as part of the campaign.
- 2.C Campaign messages and information are disseminated in formats that are inclusive of and accessible to women with disabilities experiencing or at risk of violence.

### POSSIBLE AREAS OF ACTION

- 2.1 All policies and practices need to emphasise equality as a general principle.
- 2.2 Effective awareness raising campaigns would lead to increased demand for existing services. Therefore, the services need to be adequately resourced to ensure that pathways to safety are available.

- 2.3 Awareness raising campaigns should piggy-back on state/territory prevention media campaigns, including social media marketing campaigns. They should also include images of diversity caveat (for example, CALD and Indigenous) and intended and unintended consequences.
- 2.4 The National Foundation on the Prevention of Violence Against Women to include prevention work specific to violence against women with disabilities.

## AREA 3 EDUCATION AND TRAINING FOR SERVICE PROVIDERS

### PRINCIPLE

Organisations across all relevant service sectors are supported to work within a human rights framework which treats all clients with dignity and respect, recognises the presence of violence in the lives of women with disability, and enables all staff to receive induction and training that is tailored to their position around intersecting issues of violence, gender and disability.

### STRATEGIES

- 3.A Organisations across all relevant service sectors undertake education and training to foster a culture of understanding and recognition of violence against women and girls with disabilities and use this understanding to inform their strategic approach to capacity building.
- 3.B Competency based training on human rights and the intersection of disability, gender and violence provided for personnel working within the disability service sector.
- 3.C Workforce training includes consideration of the specific intersectional experiences of disability, gender and violence, in the context of Indigeneity, cultural diversity, and other dimensions of social disadvantage.
- 3.D Justice and legal workforce training be strengthened to recognise and support disclosure and redress particularly in relation to issues of family and domestic violence.

## POSSIBLE AREAS OF ACTION

- 3.1 Health Workforce Australia works with professional health industry bodies to develop and implement disability, gender and human rights specific curriculum components to assist in the training of health practitioners.
- 3.2 Core training units that can be reorganised and utilised to develop a skills set around gender-based violence against women with disabilities could be developed under the Industry Skills Council.
- 3.3 All front line personnel working within the National Disability Insurance Scheme, particularly local area coordinators and planners be required by the National Disability Insurance Agency to undertake professional training on human rights and the intersection of disability, gender and violence.
- 3.4 Staff training programs and cross sector collaborative frameworks are built into quality assurance and assessment systems established federally under the National Disability Insurance Scheme and in line with National Disability Standards.
- 3.5 Family/Domestic Violence and Sexual Assault Training Programs for professionals, including police, working in the family law system (such as the AVERT Family Violence Training Program and the Family Law Detection of Overall Risk Screen (DOORS) Framework) could be strengthened by including information on gender, disability and violence in all components, including the 'Responding to Diversity' component.

## AREA 4 SERVICE SECTOR DEVELOPMENT AND REFORM

### PRINCIPLE

All government, community and for-profit service sectors are developed to be inclusive of women and girls with disabilities and their concerns.

### STRATEGIES

- 4.A Women with disabilities perform a leadership role in governance and advisory, policy and service structures, including decisions concerning service sector development and reform.
- 4.B Services work together in bringing about a change in culture and attitudes within organisations, and use this process to drive improvements to policies, protocols and practices in responding to violence against women and girls with disabilities.
- 4.C When policies and procedures are developed, specific consideration is given to addressing the diverse needs and circumstances of women and girls with disabilities.

## POSSIBLE AREAS OF ACTION

- 4.1 Establish clear measurable targets or quotas for women with disabilities in leadership positions across government, community and for-profit sectors, ensuring that organisations and participants are sufficiently resourced to enact this leadership.
- 4.2 Mandatory requirement of representation of women with disabilities in service-level governance and advisory of all services operating under National Disability Insurance Scheme regulatory framework.

## AREA 5 LEGISLATION, NATIONAL AGREEMENTS AND POLICY FRAMEWORKS

### PRINCIPLE

Legislation, national agreements and policy are directed within a human rights framework so that they actively prevent violence; enact legislative responses that respond effectively to violence; force service systems to respond effectively to varying forms of violence; prevent further harm following entry into the service system; and enable women with disabilities to respond to violence perpetrated against them as active agents.

### STRATEGIES

- 5.A Commonwealth/State/Territory legislation gives effect to Australia's obligations under ratified human rights treaties.
- 5.B Policy frameworks facilitate a co-ordinated cross-sector approach across disability and violence against women sectors.
- 5.C Reporting measures to track progress on violence against women and girls with disabilities are included in relevant Implementation Plans and their jurisdictional operationalisation against for example the *National Plan to Reduce Violence Against Women and their Children 2010-2022* and the *National Disability Strategy 2010-2020* which commits all Australian governments to continue to consider measures to reduce violence, abuse and neglect of people with disability through all mainstream and disability-specific policies, programs and services over the life of the strategy.
- 5.D Justice sector facilitates access for women and girls with disabilities experiencing or at risk of violence.

### POSSIBLE AREAS OF ACTION

- 5.1 Commonwealth/State/Territory legislation be reviewed to recognise all forms of violence against women and girls perpetrated in all settings, including institutional and congregate care settings, recognise the right of people with disabilities to live free from violence, abuse, exploitation and neglect.
- 5.2 Commonwealth/State/Territory legislation on family law and domestic and family violence acknowledge the particular impact of domestic and family violence on marginalised and vulnerable groups of people with disabilities, including Indigenous persons, LGBTQI persons, those from a CALD background, and older persons.
- 5.3 Commonwealth/State/Territory Family/ Domestic Violence Legislation could contain consistent, comprehensive definition of family/domestic violence which includes the broadest possible definition of acts of family violence and relationships within which family violence occurs.
- 5.4 COAG agrees on three key performance measures that state governments report on, as required by relevant Implementation Plans established in each jurisdiction under the *National Plan to Reduce Violence Against Women and their Children 2010-2022* and the *National Disability Strategy 2010-2020*. Performance measures should pertain to quality of life outcomes, given that these outcomes are also indicative of overall vulnerability to violence, (for example, education, active labour market participation, income).

## AREA 6 EVIDENCE GATHERING, RESEARCH AND DEVELOPMENT

### PRINCIPLE

National data definitions and collection methods capture the forms, types and frequency of violence experienced by women and girls with disabilities, and are utilised to promote research and development. Definitions of violence should reflect those set out in International Human Rights Treaties, in particular, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

### STRATEGIES

- 6.A Violence against women and girls with disabilities is recognised as a key area for future research and policy development. This research agenda could be situated and developed within the National Centre for Excellence, and would benefit from partnership agreements with disability and violence sector organisations and other national data collection agencies.
- 6.B Data on the use of relevant services by women and girls with disabilities faced with violence is collected, collated and made available to inform future policy work for strategic improvement of services.
- 6.C A National Women with Disabilities Expert Panel with diverse representation of women with disabilities be established to inform relevant agencies on the development of data collection strategies across all pertinent areas of policy and service delivery.
- 6.D Information on violence against women and girls with disabilities in Australia is incorporated in reporting to human rights treaty bodies, universal periodic reviews, reports and recommendations of the UN Commission on the Status of Women, reporting to special rapporteurs, and within the post-2015 development framework.

### POSSIBLE AREAS OF ACTION

- 6.1 The National Centre of Excellence develops the National Research Agenda and includes as a priority research area, addressing violence against women and girls with disabilities. This includes prioritising initiatives which are informed by the findings and outcomes of the Stop the Violence Project and which improve policy and integrated service delivery in preventing and responding to, violence against women and girls with disabilities.
- 6.2 Existing service funding arrangements are restructured to enable the collection, collation and availability of data on the use of relevant services by women and girls with disabilities faced with violence for the purposes of service development.
- 6.3 Relevant national surveys such as the *National Community Attitudes Survey* (NCAS) and the *National Personal Safety Survey* (PSS) include disability and gender specific indicators and provide disaggregated data in reporting.
- 6.4 The *National Gender Equality Indicators Australia* are strengthened by including disaggregated reporting and by developing specific disability indicators for each of the six key domains (Economic security, Education, Health, Work and family balance, Safety and justice, and Democracy, governance and citizenship).
- 6.5 A national women with disabilities Expert Panel is established and resourced to advise the ABS on future development of the *National Personal Safety Survey* and the *National Community Attitudes Survey* and other relevant national, State/Territory data collection processes.

- 6.6 Recognising, responding to, and preventing violence against women and girls with disabilities is integrated throughout the National Evaluation Framework to be developed for the *National Plan to Reduce Violence against Women and their Children 2010-2022*. Women with disabilities are represented on any advisory/reference structures established to oversee development of the National Evaluation Framework.
- 6.7 As part of the review of the National Disability Agreement, agreement from Council of Australian Governments is sought that data on violence experienced by people with disabilities be collected by all disability services, and this data be disaggregated according to gender, context where violence occurred, and the perpetrator of violence.
- 6.8 The National Disability Strategy could pick up indicators of violence against people with disability that are disaggregated according to gender, context where violence occurred, and the perpetrator of violence. The National Disability Strategy includes indicators of violence against people with disability that are disaggregated according to gender, context where violence occurred, and the perpetrator of violence.

## AREA 7 ESTABLISHMENT AND DEVELOPMENT OF THE VIRTUAL CENTRE FOR THE PREVENTION OF VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES

### MECHANISM

Symposium participants proposed that a *Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities* be established to function as an online 'one stop' resource designed to serve and meet the needs of a wide range of users, including women with disabilities; policymakers; front line service providers; researchers; program developers; legislators; academics; teachers; students; the broader community and more. It would have international applicability and serve as model for other countries in their efforts to promote the rights of women and girls with disabilities to live free from violence, abuse, neglect and exploitation as part of Australia's international human rights obligations. The *Virtual Centre* would foster and support evidence-based approaches to more efficiently and effectively design, implement, monitor and evaluate initiatives to prevent and respond to violence against women and girls with disabilities.

### STRATEGIES

- 7.A The *Virtual Centre* could encompass the following elements:
- Principles and guidelines for good practice approaches to violence against women and girls with disabilities;
  - Promising and/or good practice models and approaches in legislation, policy, program and service responses;
  - Leading tools and evidence on what works to address violence against women and girls with disabilities;



- A compendium of contemporary resource materials available worldwide;
  - Models, responses and approaches to support engagement and participation of women and girls with disabilities;
  - A repository of historical information and resources;
  - Human rights conventions, instruments, declarations and reference materials relating to gender, disability, violence and intersectionality;
  - Scholarly, academic, and other research sources;
  - Sources of expertise;
  - Interactive spaces for communication and collaboration; and
  - The UN Knowledge Centre on Violence Against Women is a model with international standing on which the Virtual Centre could be modelled.
- 7.B To ensure continued development, longevity and sustainability, the *Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities* could be housed within the National Centre of Excellence, supported by a technical, administrative and support team that maintains and updates the Virtual Centre, overseen by an Expert Panel made up of women with disabilities and selected key stakeholders. The Virtual Centre could be developed utilising a Content Management System (CMS) platform, with site accessibility being a key principle in design and usability.

## POSSIBLE AREAS OF ACTION

- 7.1 Map the range of public, private and community organisations that could act as partners and potential partners in the development and sustainability of the Virtual Centre (for example, the National Centre for Excellence, the National Foundation for the Prevention of Violence Against Women, the National Disability Insurance Agency, and the National Disability Research Agenda).
- 7.2 Explore State/Territory governments' contribution to the establishment of the Virtual Centre.
- 7.3 The National Centre for Excellence considers embedding the Virtual Centre within its future research priorities (write formally to the boards of the *National Centre for Excellence*, the *National Foundation for the Prevention of Violence Against Women* and the *National Disability Insurance Agency* to promote the concept).
- 7.4 Explore opportunities to resource the sourcing of the Virtual Centre under the second stage of the *National Plan to Reduce Violence against Women and their Children 2010-2022* and through the NDIS workforce development fund.
- 7.5 Ensure that women with disabilities drive the development of the Virtual Centre, taking leadership roles within advisory and governance structures, and that the Centre remains accessible to women with disabilities in all required formats.

## AREA 8 ESTABLISHMENT OF A NATIONAL WOMEN WITH DISABILITIES EXPERT PANEL ON THE PREVENTION OF VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES

### MECHANISM

A National Women with Disabilities Expert Panel on the Prevention of Violence Against Women and Girls with Disabilities, including representation of women with disabilities, could provide high level strategic direction to build an effective, integrated legislative, policy, program and service response to address and prevent violence against women and girls with disabilities. It could:

- develop, drive and monitor the key strategies for action under the six key areas of reform;
- have a direct link to relevant national reference groups and panels such as the previous government's National Plan Implementation Panel (NPIP) and the National Disability Strategy Implementation Reference Group (NDSIRG);
- establish priority key strategies for reform;
- determine responsibility and resource implications for the key strategies for reform; and
- provide advice on data collection.

### STRATEGY

- 8.A An appropriate national expert panel could be appointed under the second stage of the *National Plan to Reduce Violence against Women and their Children 2010-2022* to provide high level strategic direction to build an effective, integrated legislative, policy, program and service response to address and prevent violence against women and girls with disabilities (for example, under the former government's NPIP).

### POSSIBLE AREAS OF ACTION

- 8.1 The National Disability Strategy (NDS) pick up indicators of violence against people with disability that are disaggregated according to gender, context where violence occurred, and the perpetrator of violence.
- 8.2 As part of the review of the National Disability Agreement, seek agreement from Council of Australian Governments that data on violence experienced by people with disabilities is collected by all disability services, and this data be disaggregated according to gender, context where violence occurred, and the perpetrator of violence.
- 8.3 The composition of the Women with Disabilities Expert Panel includes representation from Women With Disabilities Australia, the National Centre of Excellence, the Foundation to Prevent Violence Against Women and their Children, governments, community agencies, and representation of women with cognitive impairments.
- 8.4 Advocate for the continuation of the Select Council on Women's Issues (SCWI) to provide strong leadership for states and territories to work collaboratively to improve policy and programs to assist in reducing family violence against women and girls with disabilities as a key priority in the Second Action Plan.



## APPENDICES

### COMMUNIQUE FROM THE NATIONAL SYMPOSIUM

#### STOP THE VIOLENCE PROJECT (STVP) NATIONAL SYMPOSIUM COMMUNIQUE – VIOLENCE PREVENTION AND RESPONSE FOR WOMEN AND GIRLS WITH DISABILITIES

On 25 October 2013, the Minister Assisting the Prime Minister for Women, Senator the Hon Michaelia Cash opened the Stop the Violence Project (STVP) National Symposium – *violence prevention and response for women and girls with disabilities*.

The National Symposium was hosted by Sex Discrimination Commissioner and Chair of the Stop the Violence Project Steering Group, Ms Elizabeth Broderick.

The need for targeted measures to address violence against women and girls with disabilities, in order for them to participate as full and equal citizens in Australian society, has been identified as a priority in the *National Plan to Reduce Violence against Women and their Children 2010-2022*. The National Plan recognises that in Australia, women and girls with disabilities experience high levels of domestic and family violence and sexual assault, and have high unmet needs in terms of access to domestic violence, sexual assault and related community services.

In her opening address, Minister Cash delivered a message from the Prime Minister, the Hon Tony Abbott MP:

*"Violence against women and girls is utterly unacceptable. It is unacceptable in Australia and unacceptable across the world. The Stop the Violence National Symposium is confronting the serious issue of violence against women and girls. In particular it will focus on confronting violence against women and girls with disabilities. The Symposium is also promoting the National Plan to Reduce Violence against Women and their Children. I am working with my colleague and Minister Assisting for Women, Senator the Hon Michaelia Cash, to ensure the National Plan is implemented, is effective and supports our most vulnerable. I congratulate Women With Disabilities Australia, People With Disability Australia and the University of New South Wales for your work on the Stop the Violence Project and for organising this event. I send my best wishes for a successful event."*

Minister Cash also stated:

*"We are all here today to recognise the very particular needs of women with disabilities who experience violence. It's a fact, we all know it, that women with disabilities are more vulnerable to violence than other women. Many women with a disability face additional problems in accessing appropriate support, and we all know the reality is that fewer have the option of escaping violence. We also hear, very disappointingly, of too many stories of violence within supported care and residential care facilities. Again, completely, totally and utterly unacceptable...."*

*"...In relation to the National Plan, many of you whom I had the opportunity of meeting with when I was the Shadow Parliamentary Secretary would know that I am 110 per cent committed to the implementation of the National Plan. We are now at the end of the first phase of the National Plan... We have made some great progress under phase one. However, there is still work to do. The Prime Minister and I are committed to working with each and every one of you to ensure that the next phase of the National Plan ensures that we take a step-up in reducing violence against women and children."*

Commissioner Broderick warmly welcomed the commitment to National Plan implementation made by the Prime Minister and Minister Cash. She highlighted the recent recommendation made by the United Nations Committee on the Rights of Persons with Disabilities "that Australia should include a more comprehensive consideration of women with disabilities in public programs and policies on the prevention of gender based violence, particularly so as to ensure access for women with disabilities to an effective integrated response system".

The first plenary session of the National Symposium outlined the key issues in violence and women and girls with disabilities. President of Women With Disabilities Australia (WWDA), Ms Karin Swift provided an introduction to the issue, providing information on the higher prevalence of all forms violence experienced by women with disability, and stating that "when gender and disability intersect, violence has unique causes, takes on unique forms and results in unique consequences".

As part of a panel, four women with disabilities presented on their experience and knowledge of the diverse and unique ways that violence occurs and affects women and girls with disabilities:

- Ms Gayle Rankine, Chairperson of First Peoples Disability Network (FPDN) highlighted the lack of support and protection and the greater risks for Indigenous women with disability in urban, rural and remote settings.

- Ms Nihal Iscel, Advocacy Manager, Ethnic Disability Advocacy Centre WA outlined issues for women with disability from non-English speaking and culturally and linguistically diverse backgrounds.
- Ms Janice Slattery, Self-Advocate and Peer Educator and Researcher discussed issues for women with intellectual disability and the research and training she conducts in this area.
- Ms Margie Charlesworth, Vice-President of WWDA spoke about barriers to accessing justice for women with communication impairments, who are often not believed or viewed as credible.

The second plenary of the National Symposium outlined the challenges and opportunities for change, and was introduced by Disability Discrimination Commissioner, Mr Graeme Innes.

Commissioner Innes outlined the gaps in both the current legislative and policy frameworks that focus on disability and those that focus on the prevention of violence against women. These gaps largely arise "because the intersection between gender and disability is generally not taken into account... and because legislative and policy frameworks lack a human rights context in relation to the human rights treaties that Australia has ratified".

The second panel was made up of researchers, practitioners and advocates, who provided an overview of key gaps in a range of service systems, including disability, mental health and justice service systems.

Ms Debbie Kilroy, CEO of Sisters Inside discussed the specific risks of violence and the barriers embedded in the justice system for women with disabilities, and presented disturbing examples of situations experienced by women with disabilities.

Dr Gabrielle Drake, lecturer and researcher at the University of Western Sydney described the appalling situation experienced by women with disabilities living in boarding houses in NSW, and the daily risks of violence they experience in these institutional settings.

Dr Leanne Dowse, Senior Researcher at UNSW for the STVP outlined the evidence gathering process, the key areas identified for further action and the implications of the findings for good policy and practice.

In the afternoon, participants worked in pre-assigned groups to identify key issues, measures and actions to address the eight key areas emerging from the evidence base:

- Establishment and Development of the Virtual Centre for the Prevention of Violence Against Women and Girls with Disabilities
- Establishment of a National High Level Inter-Agency Taskforce on the Prevention of Violence Against Women and Girls with Disabilities
- Evidence Gathering, Research and Development
- Information, Education and Capacity Building for Women and Girls with Disabilities
- Awareness Raising for the Broader Community
- Education and Training for Service Providers
- Service Sector Development and Reform
- Legislation, National Agreements and Policy Frameworks.

The information obtained from workshops will inform the principles, strategies and actions needed to ensure effective violence prevention and response for women and girls with disabilities. These will be outlined in the National Symposium Report of Proceedings and Outcomes to be provided to the Department of Social Services, and publicly released in December 2013.

Commissioner Broderick closed the National Symposium, thanking participants for their commitment and hard work throughout the day:

*"The National Symposium enabled experts from a broad range of policy and service sectors to assist in identifying measures for cross-sector service system reform. However, this is only the beginning of discussion on this important issue, and the day's deliberations have given a sound platform for further work and improvements for women and girls with disabilities who experience, or are at risk of violence. We need to ensure that this sound platform is part of phase two of the National Plan, as this is critical to ensure that violence prevention and response is inclusive of women and girls with disabilities."*

Further information about the National Symposium, including the Background Paper, Discussion Paper, presentation podcasts and transcripts and the Report of Proceedings and Outcomes are available on the STVP website, [www.stvp.org.au](http://www.stvp.org.au)

## ABOUT THE STOP THE VIOLENCE PROJECT

The STVP is being undertaken by Women with Disabilities Australia (WWDA) with support from People with Disability Australia (PWDA) and the University of New South Wales (UNSW). It has been funded by the Department of Social Services (DSS) through its *National Plan to Reduce Violence against Women and their Children 2010-2022*.

The STVP also aligns with the *National Disability Strategy 2010-2020* (NDS), which was formally endorsed by the Council of Australian Governments (COAG) on 13 February 2011.

The STVP is overseen by a Project Steering Group (PSG), which is chaired by **Ms Elizabeth Broderick**, Sex Discrimination Commissioner at the Australian Human Rights Commission. The other members of the PSG are:

**Ms Julia Braybrooks**  
Women NSW

**Ms Vanessa Swan**  
Office for Women (South Australia)

**Ms Mary Bereux**  
Office of Women's Affairs, Dept. of Human Services (Victoria)

**Ms Rebecca Moles**  
Dept. of Premier and Cabinet (Tasmania)

**Ms Fiona Baker**  
Office for Women (Australian Capital Territory)

**Ms Suzanne Everingham**  
Office of Women's Advancement (Northern Territory)

**Ms Wendy Murray**  
Disability Services Commission (Western Australia)

**Ms Philippa Angley**  
National Disability Services

**Ms Stephanie Gotlib**  
Children with Disability Australia

**Ms Julie Oberin / Ms Taryn Champion**  
Australian Women Against Violence Alliance

**Ms Cassandra Goldie**  
Australian Council of Social Services

**Ms Annie Parkinson**  
Women With Disabilities Australia

**Ms Therese Sands**  
People with Disability Australia

**Dr Leanne Dowse**  
The University of New South Wales

**Dr Karen Soldatic**  
The University of New South Wales

Queensland is not represented on the PSG, but is participating in out-of-session discussions and activities. The Queensland point of contact for the STVP is the Violence Prevention Team, Department of Communities, Child Safety and Disability Services.

The STVP is based on the vision and foundational work of Ms Carolyn Frohmader, Executive Director, Women With Disabilities Australia.

The PSG Secretariat can be contacted by email, [stvp@pwd.org.au](mailto:stvp@pwd.org.au)



## NATIONAL SYMPOSIUM ATTENDEES

	Ministers	
1	Senator the Hon Michaelia Cash	Minister Assisting the Prime Minister for Women
	Project Steering Group (PSG)	Organisation
2	Elizabeth Broderick (PSG Chair)	Sex Discrimination Commissioner Australian Human Rights Commission
3	Annie Parkinson	Former President Women With Disabilities Australia
4	Vanessa Swan	Director Office for Women (SA)
5	Fiona Baker	Manger ACT Office for Women
6	Rebecca Moles	Manger – Policy Dept. of Premier and Cabinet (TAS)
7	Julia Braybrooks on behalf of Sarah Squire	Policy Officer Women NSW
8	Julie Oberin	Chair Australian Women Against Violence Alliance
9	Philippa Angley	National Policy Manager National Disability Services
10	Cassandra Goldie	CEO Australian Council of Social Services
	Expert Consultative Group (ECG)	Organisation
11	Alison Aggarwal	Principal Adviser, Sex Discrimination Team Australian Human Rights Commission
12	Margaret Camilleri	Honorary Associate Researcher University of Ballarat
13	Margie Charlesworth	Vice President Women With Disabilities Australia
14	Samantha Connor	Coordinator Disability Clothesline
15	Gabrielle Drake	Lecturer University of Western Sydney
16	Maeve Dunnett	Trainer Insideout Disability Awareness
17	Fiona Given	Independent Consultant
18	Keran Howe	Coordinator Women With Disabilities Victoria
19	Nihal Iscel	Manager of Advocacy Services Ethnic Disability Advocacy Centre
20	Karen Jordan	Independent consultant
21	Debbie Kilroy	CEO Sister Inside

22	Gayle Rankine	Chair First People's Disability Network Australia
23	Christina Ricci	Disability Rights Team Australian Human Rights Commission
24	Christina Ryan	General Manager Advocacy for Inclusion
25	Karin Swift	President Women With Disabilities Australia
	<b>Project Implementation Committee (PIC)</b>	<b>Organisation</b>
26	Carolyn Frohmader	Executive Director Women With Disabilities Australia
27	Leanne Dowse	Senior Lecturer University of NSW
28	Karen Soldatic	Lecturer University of NSW
29	Therese Sands	Co- Chief Executive Director People With Disability Australia
30	Wendi Wicks	STVP Project Manager People With Disability Australia
31	Aminath Didi	STVP Project Coordinator University of NSW
32	Georgia van Toorn	Research Assistant University of NSW
33	Peter Darby	Information and Project Liaison Officer People With Disability Australia
	<b>Project Support</b>	<b>Organisation</b>
34	Jess Cadwallader	Advocacy Projects Officer People With Disability Australia
35	Jennifer Jones	Australian Human Rights Commission
36	Emily Maguire	Australian Human Rights Commission
	<b>Other Expert Stakeholders</b>	<b>Organisation</b>
37	James Bannister	Senior Sector Development Officer National Disability Services
38	Jennifer Clarke	Policy Officer Homelessness Australia
39	Anna Cody	Chair Community Legal Centres NSW
40	Mary Durkin	Health Disability and Community Services Commissioner ACT Human Rights Commission
41	Jennifer Ellis	Member of the South Western Sydney Institute of Domestic and Family Violence Skilled Development Strategy Team South Western Sydney Institute of TAFE NSW

42	Patsie Frawley	Research Fellow LaTrobe University
43	Selina Getley	Manager, Policy and Projects Foundation to Prevent Violence against Women and their Children
44	Louise Glanville	Acting Deputy Secretary, Strategic Policy and Coordination Group Attorney-General's Department
45	Jen Hargrave	Policy Officer Women with Disabilities Victoria
46	Graeme Innes	Disability Discrimination Commissioner Australian Human Rights Commission
47	Evan Lewis	Group Manager Department of Social Services
48	Liz Little	Chair National Association of Services Against Sexual Violence
49	Joslene Mazel	Board Member National Centre of Excellence
50	Magdalena McGuire	Research and Policy Officer Office of the Public Advocate Victoria
51	Leigh Michel	ASD Specialist
52	Sandy Miller	Deputy Chairperson National Aboriginal and Torres Strait Islander Women's Alliance
53	Clare Morton	Director Department of Justice Victoria
54	Brad Petry	Director of the National Centre for Crime and Justice Statistics Australian Bureau of Statistics
55	Janice Slattery	Individual Self-Advocate/Peer Educator and Researcher
56	Lorna Sullivan	Director Disability ACT
57	Jolanta Willington	Branch Manager Department of Social Services
58	Karen Willis	Executive Officer NSW Rape Crisis Centre



Women  
With  
Disabilities  
Australia  
(WWDA)



[www.wwda.org.au](http://www.wwda.org.au)

Women With Disabilities Australia (WWDA)

# Submission to the UN Analytical Study on Violence against Women With Disabilities

DECEMBER 2011



## PUBLISHING INFORMATION

### Submission to the Preparation Phase of the UN Analytical Study on Violence against Women and Girls with Disabilities (A/HRC/RES/17/11)

By Carolyn Frohmader for Women With Disabilities Australia  
(WWDA)

© Women With Disabilities Australia (WWDA) December 2011

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without written permission from Women With Disabilities Australia (WWDA). All possible care has been taken in the preparation of the information contained in this document. WWDA disclaims any liability for the accuracy and sufficiency of the information and under no circumstances shall be liable in negligence or otherwise in or arising out of the preparation or supply of any of the information aforesaid.

## CONTACT DETAILS

Women With Disabilities Australia (WWDA)  
PO Box 605, Rosny Park 7018 TASMANIA, AUSTRALIA  
Ph: +61 3 62448288 Fax: +61 3 62448255  
Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)  
Web: [www.wwda.org.au](http://www.wwda.org.au)

WWDA on Facebook:  
<http://www.facebook.com/pages/Women-With-Disabilities-Australia-WWDA/202081393153894>

Winner, National Human Rights Award 2001  
Winner, National Violence Prevention Award 1999  
Winner, Tasmanian Women's Safety Award 2008  
Certificate of Merit, Australian Crime & Violence Prevention Awards 2008  
Nominee, French Republic's Human Rights Prize 2003  
Nominee, UN Millennium Peace Prize for Women 2000



# CONTENTS

Introduction	4
Data and statistics	6
Legislation and policies	14
Prevention and protection	23
Prosecution and punishment	33
Recovery, rehabilitation and social reintegration	40
Appendix1: Projects on violence against women with disabilities 1990-2010	42
Appendix 2: Definitions of 'family violence' in legislation	48
Endnotes	67

# INTRODUCTION



1. Women With Disabilities Australia (WWDA)<sup>1</sup> is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA's work is grounded in a rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the rights of women with disabilities to freedom from violence, exploitation and abuse and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.<sup>2</sup>
2. Australia is a country that prides itself on ideals which include a fair go for everyone, freedom and dignity of the individual, equality of men and women, equality of opportunity, freedom from discrimination, and the right of its citizens to participate fully in the economic, political and social life of the nation.<sup>3</sup> However, these entitlements remain a distant goal for women with disabilities. In Australia today, women with disabilities are not given a 'fair go', they are denied the most fundamental rights and freedoms, they are not treated with dignity and respect, they remain profoundly more disadvantaged than their male counterparts; are systematically denied opportunity in every aspect of society; experience multiple forms of discrimination, and widespread, serious violation of their human rights. They remain largely ignored in national policies and laws, and their issues and needs are often overlooked within broader government programs and services. Negative stereotypes from both a gender and disability perspective further compound the exclusion of women with disabilities from support services, social and economic opportunities and participation in civic and community life. The deep-rooted exclusion experienced by women with disabilities in Australia continues unabated due in part to the dearth of information available on its extent or impact, and the apathy of successive Governments in acknowledging the need for such information.<sup>4</sup>

3. Violence against women with disabilities remains a key factor that undermines the ability of disabled women to participate as full and equal citizens in Australian society. Violence against women with disabilities is an intersectional category dealing with both gender-based and disability-based violence. The confluence of these two factors results in an extremely high risk of violence against women with disabilities.<sup>5</sup>

<sup>6</sup> In Australia, women with disabilities experience high levels of domestic/family violence and sexual assault, and have high levels of unmet needs in terms of access to domestic violence, sexual assault and related community support services. It is now widely acknowledged that compared to non-disabled women, women with disabilities are at greater risk of severe forms of intimate partner violence; they experience violence at significantly higher rates, more frequently, for longer, in more ways, and by more perpetrators; they have considerably fewer pathways to safety, and are less likely to report experiences of violence - yet programs and services for this group either do not exist or are extremely limited. In Australia, responses to violence against women with disabilities have traditionally been characterised by limited recognition by governments and the service sector of the nature and extent of the problem; inadequate research; incomplete or partial response structures, and scarce resources to support advocacy in the area.<sup>7 8 9</sup>

4. The duty of Governments to respect, protect, fulfil and promote human rights with regard to violence against women includes the responsibility to prevent, investigate and prosecute all forms of, and protect all women from such violence and to hold perpetrators accountable.<sup>10</sup> The responsibility of the Australian Government to address violence against women and girls with disabilities is explicitly delineated in a number of the human rights treaties it has ratified, particularly the *Convention on the Rights of Persons with Disabilities* (CRPD).<sup>11</sup> Article 16 of the CRPD (Freedom from exploitation, violence and abuse) requires states to ensure that people with disabilities are not subject to any form of exploitation, violence or abuse; requires states to protect women, children and older people with disabilities from gender and age aggravated exploitation, violence and abuse; requires states to institute measures to ensure the detection, investigation and prosecution of exploitation, abuse and neglect of people with disabilities and to promote

the physical and psychological recovery and social reintegration of victims.

5. The obligation to respect, protect and fulfil women with disabilities' right to freedom from violence, exploitation and abuse and to freedom from torture and other cruel, inhuman or degrading treatment or punishment, clearly requires Australian Governments to do much more than merely abstain from taking measures which might have a negative impact on women with disabilities. The obligation in the case of women and girls with disabilities is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women with disabilities in order to ensure that they enjoy all human rights. This invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.<sup>12</sup>
6. This Submission from Women With Disabilities Australia (WWDA) to the preparation phase of the UN *Analytical Study on Violence Against Women and Girls with Disabilities*, aims to provide an overview of the legislation, regulatory frameworks, policy, administrative procedures, services and support available within Australia to prevent and address violence against women and girls with disabilities. WWDA acknowledges that, due to time and resource constraints, this Paper does not provide a complete and detailed analysis of all mechanisms and programs across Australia's eight States and Territories. However, the information provided in this Paper does clearly demonstrate that there have been, and remain, significant systemic failures in legislation, regulatory frameworks, policy, administrative procedures, availability and accessibility of services and support, to prevent and address the epidemic that is violence against women and girls with disabilities. Underlying these systemic failures is an entrenched culture throughout all levels of Australian society that devalues, stereotypes and discriminates against women and girls with disabilities, and invariably perpetuates and legitimises not only the multiple forms of violence perpetrated against them, but also the failure of governments to recognise and take action on the issue.

# DATA AND STATISTICS

Have studies/research been conducted on the prevalence, nature, causes and impact of violence against women and girls with disabilities in different settings (family/home, work-place, medical institutions, schools, etc.?). What forms of disability and violence do they cover?

7. To date, there have been no national studies or research conducted to establish the prevalence, extent, nature, causes and impact of on violence against women and girls with disabilities in different settings. There is no data collection in Australia on violence against women with disabilities.
8. For more than a decade, WWDA has called on successive Australian Governments to commission and resource nationwide research to ascertain the prevalence, extent, nature, causes and impact of violence against women with disabilities.<sup>13 14 15</sup>The need for such research has been widely documented across a range of sectors for a number of years.<sup>16 17 18 19</sup> The critical need for Governments to accelerate their efforts in research and data collection in relation to violence against women with disabilities has also recently been re-iterated by the United Nations Human Rights Council.<sup>20</sup>
9. The Australian Government concedes that violence against women with disabilities in Australia is 'widespread'.<sup>21</sup> As recently as 24 October 2011, the Federal Minister for the Status of Women, Kate Ellis acknowledged that women with disabilities, particularly intellectual disabilities, are extraordinarily vulnerable to violence and abuse. She stated:

"We don't know the full extent, but we do know (women with disabilities) are massively over-represented in the statistics of women in Australia who are subjected to violence. We know that women with disabilities, particularly intellectual disabilities, can be



extraordinarily vulnerable and we also know there are issues around reporting and around knowing where to turn for assistance and how to avoid those sorts of relationships.”<sup>22</sup>

10. The most immediate and apparent finding in researching and analysing violence against women with disabilities in Australia, is the limited information available on any aspect of the issue. The neglect in research of women with disabilities generally has been highlighted by the United Nations Committee on the *Elimination of All forms of Discrimination Against Women (CEDAW)*, in both its 2006 and 2010 assessments of the Australian Government’s implementation of the Convention.<sup>23 24</sup> In its 2010 Concluding Comments, the CEDAW Committee made very strong recommendations regarding the need for urgent action by Australian governments in relation to women with disabilities, including the need to:

- Undertake a comprehensive assessment of the situation of women with disabilities in Australia;
- Address the abuse and violence experienced by women with disabilities living in institutions or supported accommodation;
- Adopt urgent measures to ensure that women with disabilities are better represented in decision-making and leadership positions;
- Enact national legislation prohibiting forced sterilisation of women and girls with disabilities.

11. The main indicators available to date about violence against women in Australia, come from the 1996 Australian Bureau of Statistics (ABS) *Women’s Safety Survey*<sup>25</sup> which gathered information about women’s experiences of violence, and the 2005 ABS *Personal Safety Survey* (PSS),<sup>26</sup> which collected information about both women’s and men’s experiences of violence. Both the ABS Surveys (1996, 2005) have been criticised for their limitations in providing a sufficiently comprehensive picture of violence against women.<sup>27 28 29</sup>

12. In 2004, WWDA, along with several other national disability organisations, wrote to the [then] Australian Government strongly advocating the need for the 2005 PSS to include data collection on violence against women with disabilities,<sup>30 31</sup> and calling for

further qualitative studies to expand on the Survey results, including information about women with disabilities. In response, the Government declined to act on this recommendation, suggesting that a sample size of 12,000 women ‘*may still be too small to gain accurate prevalence estimates of women with a disability who have also experienced violence*’.<sup>32</sup> A further reason given related to survey methodology: ‘*as women are most at risk of experiencing violence from someone known to them, we are aware of the sensitivities involved in surveying women with disabilities about their experience(s) of violence in the presence of a carer, who in some circumstances may be the perpetrator of violence*’ (Flanagan 2004).<sup>33</sup>

13. The next national *Personal Safety Survey* is due to be conducted in 2012, although this is yet to be confirmed. The potential 2012 PSS would build the evidence base on the nature, extent and characteristics of women’s and men’s experiences of violence in Australia. Although the next PSS will contain a disability module, the Australian Bureau of Statistics (ABS) has acknowledged that ‘*it is likely that estimates for people with disabilities will be underestimated*’.<sup>34</sup> Limitations of the 2012 PSS in relation to capturing data on violence against women with disabilities include:

- the PSS is conducted via personal interview in the respondent’s home, with a small number of interviews occurring by telephone. Eliciting good data about experiences of violence depends on the respondent clearly understanding the questions being asked, their ability to respond and the interview being able to occur in private. People with disabilities who do not meet these criteria will be ‘un-selected’ from the PSS.
- the PSS will not include residents of special dwellings (eg: boarding houses, institutions).

14. A potential source of some statistical data on violence against women with disabilities may be available through the *National Disability Abuse and Neglect Hotline*<sup>35</sup> (the ‘Hotline’). The Hotline is an Australia-wide telephone hotline for reporting abuse and neglect of people with disabilities, is fully funded by the Australian Government,<sup>36</sup> and operated on behalf of the Government by a national peak disability organisation. Its primary target group are people with disabilities who use Commonwealth, State or Territory

provided or funded disability services. Notifications of abuse and neglect are referred to relevant complaint bodies for their resolution. Statistical and other data from the Hotline is provided to the Government, however, none of this data or information is available to the public. WWDA understands that the data is disaggregated by gender, however it is unclear how the Australian Government uses the data it collects. There is no legislative base for the Hotline and it therefore has no statutory functions, powers and immunities.<sup>37</sup> It has no investigative powers, no power to compel any other agency to investigate a complaint, and no power to formally review complaint investigation processes and outcomes. The Hotline does not have any systemic investigation, inquiry or review powers, and is unable to initiate action at its own motion.<sup>38</sup> There is a clear lack of transparency relating to outcomes of notifications; there are a number of service types which are excluded from its mandate (such as licenced boarding houses), and definitions which set the scope of its work fail to incorporate a domestic context.<sup>39</sup> Although the Hotline offers potential as a mechanism in detecting, reporting and responding to violence against women with disabilities, in its current form it is severely limited.

## Government Research Initiatives

15. There have been minimal research studies initiated by Australian Governments on violence against women with disabilities.
16. In 1990, the Australian Government established a *National Committee on Violence Against Women (NCVAW)* to 'initiate research, coordinate community education and act as a forum for national consideration of legal, policy and program issues'.<sup>40</sup> The NCVAW commissioned a small project to examine the effectiveness of service delivery to women with disabilities who experience violence, representing an acknowledgment by the Australian Government that violence against women with disabilities was an issue. The study looked at access to police, legal and support services and used a qualitative framework to interview women with disabilities, service providers, relevant government agencies and non-government organisations. The NCVAW was wound up in 1993, with none of the study's recommendations being implemented.
17. In 1996, the New South Wales (NSW) Government funded a small research project to investigate access for women with disabilities to existing sexual assault services. Interviews with women with disabilities, carers and organisations identified key issues such as lack of understanding by service providers of the intersections between gender, disability and abuse; the discriminatory culture within services; lack of information for women with disabilities about abuse; and lack of access to services. Recommendations centred on empowerment, access to quality services and advocacy.<sup>41</sup> There is no information available on whether or how these recommendations were implemented.
18. In May 2008, the Australian Government established the *National Council to Reduce Violence against Women and their Children* (the Council). The Council's main role was to develop a national plan to reduce the incidence and the impact of violence against women and their children. In March 2009, the Council released *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021*,<sup>42</sup> which contained the Council's recommendations for a *National Plan to Reduce Violence against Women* to be developed and agreed by the Council of Australian Governments (COAG) and to be released in 2010.
19. *Time for Action* identified six key outcome areas<sup>43</sup>, proposed strategies and actions in each area and identified 20 high-priority actions that required an urgent response. One of these 'high-priority actions' included developing a national response to 'audit crisis accommodation services for their accessibility for all women'.<sup>44</sup> However, to date, there is no evidence that this has occurred, and it appears that it is no longer considered a priority by the Government. This is despite many years of WWDA and other stakeholders urging the Australian Government to commission a national audit of crisis accommodation services (including women's refuges) to determine their levels of accessibility and safety for women with disabilities.
20. The urgent need for improvement in data collection was also identified in *Time for Action*. A key strategy included 'build[ing] the evidence base', noting that:  
  
data relating to violence against women and their children in Australia is poor. Data on services sought by, and provided to,

victims is not readily available, and the way in which information is reported is generally inconsistent and does not allow for a comprehensive understanding of violence against women.<sup>45</sup>

21. Time for Action also found that where data exists, there are many limitations, including for example:

- *Under-reporting, particularly given sample populations of large surveys often do not reach the most vulnerable groups of women;*
- *There is an over-reliance on data not supported by in-depth, detailed research that would provide a better understanding of the relevance of different social, physical, cultural, geographical and economic contexts.*<sup>46</sup>

22. In November 2009, the Australian Government released the findings of the *National Community Attitudes towards Violence against Women Survey 2009*.<sup>47</sup> For the first time in this survey series, a limited number of questions on violence against women with disabilities were included. Some key findings from the survey about women with disabilities included:

- community awareness of violence against women with disabilities was very poor;
- few respondents recognised the greater vulnerability of women with disabilities to violence;
- only 9% of respondents agreed that *'women with intellectual disabilities are more likely to experience violence than other women'*. 69% of respondents disagreed with the statement;
- 16% agreed that *'women with physical disabilities are more likely to experience domestic violence than other women'*, but 58% disagreed;
- 76% of respondents agreed that *'few people know how often women with disabilities experience rape or sexual assault'*;
- 42% of female respondents and 35% of male respondents agreed that *'women with disabilities who report rape or sexual assault are less likely to be believed than other women'*.

23. In February 2011, the Australian Government released the *National Plan to Reduce Violence against Women*

*and their Children 2010-2022*,<sup>48</sup> which consists of four three-year Action Plans. The First Action Plan (2010–2013) includes two key *'immediate national initiatives'* specifically focused on women with disabilities. They are to:

- Investigate and promote ways to improve access and responses to services for women with disabilities.
- Support better service delivery for children, Indigenous women and women with disabilities through the development of new evidence based approaches where existing policy and service responses have proved to be inadequate.<sup>49</sup>

## Australian Research

24. The limited and fragmented work undertaken by Governments to date, is supplemented by a small number of research studies into violence against women with disabilities in Australia.

25. Examples of the work undertaken include an examination of the experiences of women while inpatients in a psychiatric hospital. This 1997 NSW study uncovered the occurrence of sexual abuse and made evident the failure of the system to respond to that abuse.<sup>50 51</sup> In another NSW study, identification of the barriers facing women with an intellectual disability when making a statement about sexual assault to police was undertaken by interviewing sexual assault workers and police officers. While the study found that women with intellectual disabilities face significant barriers in successfully making statements to police following a sexual assault, the omission of the views of the women themselves was a significant limitation of the study.<sup>52</sup>

26. The *Sexual Offences Project for Women with Disabilities*, conducted in Victoria in 2003, aimed to examine the issues and problems victim/survivors with cognitive impairment experience when reporting sexual assault and proceeding with prosecution in Victoria. Unfortunately, *'due to ethical concerns and resource constraints, as well as the varying abilities of victim/survivors to share their experiences'*, it was decided that victim/survivors would not be directly interviewed. The Project instead invited those people who work with victim/survivors to *'give case studies*



*that illustrate important issues and experiences when reporting and/or seeking access to justice*.<sup>53</sup>

27. Similarly localised, Cockram's work documenting the nature and extent of family and domestic violence against women with disabilities in Western Australia in 2003, sought to ascertain whether the needs of women with disabilities were being adequately addressed by relevant services. The accounts of women with disabilities who have histories of family and domestic violence coupled with information from service agencies, highlighted discrimination against such women by service providers across a range of sectors.<sup>54</sup>
28. A Victorian study undertaken in 2006 analysed 850 rapes reported to Victoria Police over three years, from 2000 to 2003.<sup>55</sup> In 92.5% of cases, the victims were female. More than a quarter of victims (26.5%) were identified as having a disability and, of this group, 15.6% had a psychiatric disability and 5.9% had an intellectual disability. The cases in the study involving victims with a disability were among those least likely to result in charges being laid against the offender and twice as likely to be determined as false.
29. A recent Project undertaken by the Victorian Office of the Public Advocate (OPA)<sup>56</sup> examined violence against OPA clients with cognitive impairments.<sup>57</sup> Women comprised 76% of the study. The study found that women of all ages with a range of cognitive impairments are subjected to physical, sexual, psychological, emotional and impairment-related violence, financial abuse and neglect. The study also found that, when acts of violence are not responded to appropriately, further violence is likely to be perpetrated against the person and it is less likely that the person will report it.
30. Figures from the Victorian OPA also show that in the past five years, police have examined more than 1000 cases of alleged abuse involving people with severe disabilities living in state residential care or private homes - including 282 allegations of assault, 320 of rape, and six alleged abductions or kidnapping.<sup>58</sup>
31. A recent study in NSW examined the experience of domestic violence and women with disabilities living in licensed boarding houses.<sup>59</sup> The study found that domestic violence is a daily lived experience of the women, and this situation exists largely due to *'failures in legislative frameworks, policy guidelines,*

*administrative procedures, accessibility of services and support.*' The study found that women with disabilities have limited knowledge of rights and options to be free from this form of abuse, and that they experience *'significant barriers'* in accessing domestic violence support services.

32. The lack of research on the issue of violence against women with disabilities has been identified by several writers as a major concern for some time.<sup>60</sup> The small number of Australian research studies on violence against women with disabilities that have occurred over the past twenty years, have tended to be one-off, short term, small scale, and localised to a particular State/Territory or region. Generally speaking, the majority of projects have focused on women with intellectual disabilities. The lack of independent evaluation appears to be a common theme, as does the lack of translation of findings into practice. Appendix 1 to this document provides a brief description of all known Australian projects on the issue of violence against women with disabilities for the period 1990 – 2010.

## Positive Initiatives

33. In recent times it does appear that the issue of violence against women with disabilities is slowly gaining more attention, particularly at the national policy level. In many respects, this is directly attributable to the sustained advocacy work of WWDA and its allies.
34. In early 2011, as part of the *National Plan to Reduce Violence against Women and their Children 2010-2022*, the Australian Government announced funding of up to three million dollars over three years for Community Action Grants to *'support community action to reduce violence against women through projects which prevent domestic and family violence and encourage respectful relationships*'.<sup>61</sup> The Government announced that *'priority will be given to projects that provide support to specific communities of older women, women with disabilities, culturally and linguistically diverse communities and gay and lesbian communities*.' At the time of writing, several of the seventeen successful projects are still to be publicly announced, although two of those which have been announced, will focus on violence against women with disabilities.<sup>62</sup>

35. WWDA also understands that, as part of the Australian Government's immediate response to the National Plan, the Government will commission a national reform project on *'Improving Service Delivery to Women with Disability'*. This national reform project is intended to provide an evidence base for future reform of the service system to better respond to the needs of women with disabilities. At the time of writing, this national reform project is in the preliminary planning stage and no firm details are yet available.

36. Other positive developments at the national level include, for example:

- Representation of women with disabilities on the Australian Government's national advisory structure to develop the National Plan to Reduce Violence against Women and their Children 2010-2022;
- Prioritising women with disabilities in the first Action Plan (2010–2013), including through two *'immediate national initiatives'*;
- Representation of women with disabilities on the Australian Bureau of Statistics *Personal Safety Survey 2012 Advisory Group*;
- Representation of women with disabilities on the Advisory Board of the 24 hour national counselling service 1800 RESPECT.<sup>63</sup>

*Please provide the available data on the number of women and girls with disabilities who have accessed services and programmes to prevent and address violence in the past year? Is this information disaggregated by disability, as well as by sex, age, socio-economic and ethnic backgrounds?*

37. Most services in Australia do not routinely collect disaggregated data on disability and violence, including our national data collection, hospitals, courts, and police. Little is known about the help-seeking experiences of women with disabilities experiencing (or at risk of experiencing) violence.<sup>64</sup>  
<sup>65</sup> <sup>66</sup> The lack of inclusive services and programs for women with disabilities experiencing or at risk of experiencing violence is well documented.<sup>67</sup>

38. In Australia, Governments attempt to respond to violence against women through the legal and judicial systems on the one hand and through service systems, which provide protection, support, treatment and education, on the other hand.<sup>68</sup> Women with disabilities are not only marginalised and ignored in many of these responses, but paradoxically, experience violence within and by the very systems and settings which should be affording them, care, sanctuary and protection.<sup>69</sup> <sup>70</sup>

39. The *Supported Accommodation Assistance Program* (SAAP) (replaced in January 2009 by the *National Affordable Housing Agreement*) was the Australian Government's main homeless program and, as such, funded services including women's refuges, shelters, and crisis services. The systematic exclusion of disabled women from such services has been documented for more than two decades.<sup>71</sup> In 2004, the New South Wales Ombudsman undertook an inquiry<sup>72</sup> into New South Wales SAAP agencies to determine the extent of, and reasons for, exclusion from SAAP. Overall, the inquiry found that *'the level and nature of exclusions in SAAP are extensive. In some cases, exclusions appear to be unreasonable and possibly in contravention of SAAP and anti-discrimination legislation, and SAAP standards and guidelines'*. Disabled people, including people with physical impairments, intellectual impairments, acquired brain injuries, along with people with mental illnesses, were one of the most significant groups affected by exclusion from SAAP. The inquiry found that a significant proportion of exclusions were based on 'global' policies of turning away all individuals belonging to a particular population group or sharing similar characteristics with a group. Reasons given by service providers for exclusions included limited staffing levels, incompatibility with other clients/residents, industrial legislative issues for staff, lack of physical access to buildings and lack of staff expertise and skills.<sup>73</sup>

40. It is well documented that domestic and family violence is one of the major factors in homelessness.<sup>74</sup>  
<sup>75</sup> And it is clear that women with disabilities are over-represented in the factors that contribute to homelessness.<sup>76</sup> Despite this, women with disabilities remain excluded from all levels of the National Affordable Housing Agreement – the primary policy and program response designed to address homelessness in Australia.

41. On 1<sup>st</sup> July 2011, the Australian Government operationalised the new *National Minimum Data Set for Specialist Homelessness Services* (SHSNMDS). The SHSNMDS aims to provide quality information about people who are either homeless or at risk of homelessness and who are seeking services from specialist homelessness agencies<sup>77</sup> (including women's refuges, shelters, and crisis services). Many specialist homelessness services also deliver prevention and early intervention programs.<sup>78</sup> However, the new SHS NMDS does not include an indicator for disability. Clearly, the importance of the SHS NMDS in capturing data on women with disabilities ought to be a critical mechanism in promoting their access to specialist homelessness services, including women's refuges. It is unlikely that access and responses to such services will improve whilst disabled women remain invisible and ignored in such significant national policy initiatives as the SHS NMDS.

*Please provide available data on the number of households in which persons with disabilities reside. How many of these are women-headed households?*

42. There are two million women with disabilities living in Australia, making up 20.1% of the population of Australian women, but apart from that, gender and disability data is scarce. For more than a decade now, WWDA has found that one of the greatest difficulties in determining and substantiating the needs and human rights violations of women with disabilities in Australia is the acute lack of available gender and disability specific data, research and information - at all levels of Government and for any issue.
43. The Australian Bureau of Statistics (ABS) conducts a number of surveys that provide data on disability at the population level. The most comprehensive is the (national) *Survey of Disability, Ageing and Carers* (SDAC),<sup>79</sup> which collects information about a wide range of impairments, activity limitations and participation restrictions, and their effects on the everyday lives of people with disability, older people and their carers. Less detailed but conceptually similar disability data are available in other data sources, including the *Census of Population and Housing*<sup>80</sup> and the *General Social Survey* (GSS).<sup>81</sup>

44. However, although some data is available (through the SDAC) on the number of households in which some people with disabilities reside, this data is not disaggregated by gender. Special tabulations of data from the SDAC are available on request, however this is as a charged service. This means that any specific tabulations seeking disaggregated data by gender, would need to be purchased at a financial cost to those seeking the data.

*Please provide any statistics, information or studies on disability/ies resulting from violence against women and girls?*

45. There is very little information in Australia on women with disabilities who have acquired their disability as a result of violence, despite the fact that violence can cause acute and chronic injuries that may lead directly to disability as well as leading indirectly to disabilities through distress and adverse lifestyle or coping strategies.<sup>82</sup>

"When I was 16 years old, my boyfriend bashed me almost to death. He beat me so badly I suffered a severe brain injury and was in a coma for four months. That evening when he bashed me he repeatedly stomped on and kicked my head. While lying in my hospital bed my family and nursing staff could see the imprint of his shoe in my very swollen face."<sup>83</sup>

46. Cockram's 2003 study in Western Australia found that 38% of abused women with disabilities serviced by that State's violence and/or disability services in a two year period, had acquired their disability as a direct result of the abuse.<sup>84</sup> This is corroborated by US studies which suggest that of the population of women with disabilities, in approximately 40% of instances their disabilities are a result of violence perpetrated against them by either their partners or caregivers.<sup>85</sup>
47. An Australian Senate Inquiry in 2003 into '*Children In Institutional Care*' highlighted the many hundreds of children in institutional care who acquired their disabilities as a result of the violence perpetrated against them while in 'care'. The Inquiry received evidence of '*general physical, psychological and dental health problems through to severe mental*

*health issues of depression and post-traumatic stress disorder’;<sup>86</sup> along with reports from many care leavers that they acquired their disabilities as a result of being assaulted in the institutions. According to the Inquiry’s Report, ‘the outcome of serious abuse, assaults and deprivation suffered by many care leavers has had a complex, serious and negative impact on their lives’.<sup>87</sup>*

48. A 2009 report by the Family Law Council<sup>88</sup> highlights data that victims of family violence receive more psychiatric treatment and have an increased incidence of attempted suicide and alcohol abuse than the general population.<sup>89</sup>
49. Similarly, a 2004 study in Victoria,<sup>90</sup> which measured the burden of disease caused by intimate partner violence found that intimate partner violence:
  - has wide-ranging and persistent effects on women’s physical and mental health;
  - contributes nine per cent (9%) to the total disease burden in Victorian women aged 15–44 and 3 per cent in all Victorian women;
  - is the leading contributor to death, disability and illness in Victorian women aged 15–44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity.

In relation to women with disabilities, the study found that:

women with disabilities are under-represented in existing prevalence studies. These women may be particularly vulnerable to violence or its health impacts, primarily because they are less likely to have the social supports and economic resources required to protect themselves from or to leave a violent relationship. Low participation in existing studies by these women also worked against comparing the burden experienced by them in this particular study.<sup>91</sup>

50. It is widely acknowledged that Indigenous Australians have rates of ill-health and disability substantially higher than other Australians.<sup>92</sup> Australian Bureau of Statistics data shows that nationally, 50% of Indigenous Australians aged 15 years and over have a disability or long-term health condition. Over half are female (51%).<sup>93</sup> Indigenous women are 35 times

more likely to suffer family violence<sup>94</sup> and sustain serious injury requiring hospitalisation, and 10 times more likely to die due to family violence, than non-Indigenous women.<sup>95</sup>

51. Research undertaken as part of the *National Plan to Reduce Violence against Women and their Children 2010-2022* looked at the economic cost of domestic violence in Australia.<sup>96</sup> It found that in 2009-10, it was estimated that violence against women and their children cost the Australian economy an estimated \$13.6 billion, and that, without appropriate action to address violence against women and their children, an estimated three-quarters of a million Australian women will experience and report violence in the period of 2021-22, costing the Australian economy an estimated \$15.6 billion. In relation to women with disabilities, it found that:

without appropriate action the estimated cost to the Australian economy of violence perpetrated against women with disabilities in 2021-22 will be \$3.9 billion, representing 25% of the total cost of the total cost of violence in 2021-22.<sup>97</sup>

52. There have been a number of media reports over the years of women who have sustained horrific injuries and permanent disabilities as a result of violence perpetrated against them. For example, in 2003, a 31 year old man raped and assaulted a colleague after a work function in Victoria. After raping his victim in the stairwell of a building, the man walked out of the building, looked up and down the street, and then returned to repeatedly stomp on her head. The 30 year old woman was admitted to hospital with facial fractures, a partly amputated right ear, brain damage and serious vaginal and anal injuries. The offender was subsequently sentenced to serve a minimum of 12 years in prison.<sup>98 99</sup>

# LEGISLATION AND POLICIES

*Is there a legal framework addressing violence against women and girls with disability in different contexts (within the family, at the community and in the workplace, and in State and non-State institutions such as medical, education and other service providing institutions)?*

53. In Australia, there is no uniform definition or understanding of what constitutes violence against women.<sup>100</sup> Legislation designed to protect individuals from family and domestic violence is the responsibility of the States and Territories. Generally, violence against women is understood in the context of 'domestic', 'spousal' or 'family' violence. The legal definition of domestic violence for example, varies across jurisdictions because of differences in legislation.<sup>101</sup> Appendix Two provides definitions of 'family/domestic violence' in relevant Commonwealth/State/Territory legislation.<sup>102</sup>
54. Most of the Australian legislation designed to protect individuals from family and domestic violence defines what constitutes a '*domestic relationship*' and some of these definitions are more inclusive than others, including for example, gay, lesbian and transgender relationships, siblings, children, non-partner family members, and so on. Some also include 'informal care relationships' which apply to domestic support and personal care relationships provided without fee or reward, and which are not under an employment relationship between the persons; and/or not on behalf of another person or an organisation.<sup>103</sup>
55. Despite the many and varied definitions within the various Australian laws of what constitutes domestic violence, family violence, domestic relationships, significant persons, relevant persons and so on, most of the current laws do not contain definitions which specifically encompass the range of domestic/family settings in which women with disabilities may live (such as group homes, institutions), nor do they contain definitions which capture and encompass



the various forms of violence as experienced by women with disabilities. Because these experiences may not fit either traditional, or contemporary definitions, violence against women with disabilities often goes unidentified.<sup>104</sup> It is nominally possible for women with disabilities who experience violence to take measures such as apprehended or personal violence orders. In practice however, for women with intellectual disabilities who live in group homes for example, recognition of the specific support needs of such women is limited and their access to effective protection, rather than promoted by legislation, is dependent on mediation and intervention by others such as staff or carers, who may also be perpetrators.

56. The *Disability Discrimination Act 1992* (Cth) (DDA) represents a rights-based approach to establishing the legal right for disabled people to be free from discrimination and to participate in the community in the same way as non-disabled people.<sup>105</sup> Compliance with the DDA is driven mainly by a system of individual complaints, through which people with disabilities enforce their rights. Many women with disabilities face significant barriers or disincentives to using the complaints process, including for example: lack of awareness of the DDA; the complexity and potential formality of the process; the fear of victimisation; the onus on the complainant to prove their complaint; the unequal financial and legal resources of complainants and respondents; the financial and non-financial costs involved; and, the lack of support and assistance in preparing for, and going through the process.<sup>106</sup>

<sup>107</sup> <sup>108</sup> The DDA has not been used in relation to violence against women with disabilities, as it is essentially designed to prohibit discrimination against people with disabilities in the areas of employment, education, the provision of goods, services and facilities, and access to premises.

57. Australian Guardianship law is the key regulatory mechanism for protecting the health and human rights of young persons, adults with disabilities and the elderly, and yet it remains understudied and misunderstood as a body of knowledge.<sup>109</sup> Australia has eight different guardianship regimes, which vary widely in their forms of regulation. Guardianship legislation is enacted through State and Territory based Guardianship Tribunals/Boards.<sup>110</sup> The roles of Guardianship Tribunals/Boards vary but can include for example:

- facilitating decision making for people with disabilities who lack the capacity to make certain decisions themselves;
- appointing guardians and financial managers, and consents to medical and dental treatment;
- investigating claims of exploitation, abuse or neglect;
- consenting to a "special medical procedure", such as 'a procedure intended or likely to cause infertility'.

58. Most States and Territories of Australia also have an independent body (such as the Victorian OPA), which acts on behalf of, and advocates for, people with a decision-making disability. The roles and responsibilities differ from State to State, however, they include promoting the rights of people with disabilities and protecting them from exploitation and abuse. This can include investigating the circumstances of a person who is believed to have decision-making incapacity and is at risk in some way.<sup>111</sup> However, Public Advocates have recently spoken out about their lack of investigative powers and also the failure of current laws in protecting people with disabilities from violence and abuse.<sup>112</sup> <sup>113</sup> For example, under current Guardianship Laws in Victoria, the Public Advocate has only the power to examine alleged mistreatment involving people who are formally placed under her guardianship or who are being considered for guardianship. This is done through an order by the Victorian Civil and Administrative Tribunal (VCAT).<sup>114</sup> But many people being abused may not be subject to a guardianship order, meaning that large numbers of the state's most vulnerable people are at risk. <sup>115</sup> According to Colleen Pearce, the Public Advocate in Victoria:

"There's a widespread expectation that the Public Advocate is going to be able to investigate situations of abuse involving a person with a disability, and that is not necessarily the case. We think there are large numbers of people [at risk], but it's really hard to quantify and that's partly because abuse against people with a disability is really hidden. It occurs in a government-run institution or in people's private homes."<sup>116</sup>

*Are practices such as 1) forced psychiatric intervention, 2) forced institutionalization, 3) solitary confinement and restraint in institutions, 4) forced drug and electroshock treatment, 5) forced abortion 6) forced sterilization and 7) harmful practices, prohibited by law?*

## Forced Sterilisation

59. In Australia, the legal position on sterilisation varies from jurisdiction to jurisdiction.<sup>117</sup> From 2003 to 2007, in an attempt to 'minimise the risk of unauthorised sterilisations occurring',<sup>118</sup> the Australian Government began to address non-therapeutic sterilisation of children [girls] by drafting national, uniform legislation (ref). However, the goal of this legislation was not to prohibit forced sterilisation of girls with disabilities, but instead to regulate who could authorise non-therapeutic sterilisations of minors with 'decision-making disabilities'. The draft legislation was strongly opposed by disability and human rights organisations on the grounds that it did not clearly prohibit sterilisation in all non-therapeutic circumstances, it only applied to children with intellectual disabilities, and it applied a broad test for the judicial authorisation of sterilisation. Critically, the primary emphasis of the draft legislation was not on the prohibition of this human rights abuse but on the elaboration of the circumstances and principles under which it could occur – which were essentially permissive rather than protective.
60. The Australian Government discontinued this work in 2007 because it believed that sterilisation of girls with disabilities had declined and that existing guardianship and court mechanisms for authorising sterilisation procedures worked adequately.<sup>119</sup> This was incorrect, and, to date, existing State and Territory legislation and federal court mechanisms have been ineffective in eliminating non-therapeutic, forced sterilisations of young girls with disabilities. Anecdotal reports and health insurance statistics provide evidence that non-therapeutic sterilisation of girls with disabilities has occurred in greater numbers than officially reported; that it occurs without authorisation by courts and

tribunals; and that these procedures are actively sought (by parents and carers) in other jurisdictions both within Australia and in other countries. Current domestic law does not prevent children with disabilities from being taken out of Australia to another country to have the sterilisation procedure performed.<sup>120</sup>

61. In late June 2011, WWDA submitted a formal communication to the United Nations regarding the ongoing practice of forced sterilisation in Australia<sup>121</sup>. WWDA's Submission was sent simultaneously to four of the United Nations Special Rapporteurs,<sup>122</sup> requesting intervention to urge the Australian Government to comply with the recommendations of the *Committee on the Elimination of Discrimination against Women* (July 2010),<sup>123</sup> the *Committee on the Rights of the Child* (October 2005),<sup>124</sup> and the *Human Rights Council* (January 2011)<sup>125</sup> to act immediately to develop national legislation prohibiting the non-therapeutic sterilisation of girls and adult women with disabilities in the absence of their fully informed and free consent. WWDA's Submission further requested assistance from the Special Rapporteurs to ensure that the Australian government implement a range of strategies to enable women with disabilities to realise their right to health, their right to freedom from violence, their rights to reproductive freedom and to found a family, and their right to freedom from torture or cruel, inhuman or degrading treatment or punishment.
62. In late 2011, WWDA collaborated on the development of an international Briefing Paper on *Sterilization of Women and Girls with Disabilities*.<sup>126</sup> This briefing paper has been jointly prepared by WWDA, Human Rights Watch (HRW), the Open Society Foundations, and the International Disability Alliance (IDA) as part of the *Global Campaign to Stop Torture in Health Care*.<sup>127</sup> The paper gives a background to the issue of forced sterilisation, outlines various international human rights standards that prohibit forced sterilisation, and offers several recommendations for improving laws, policies, and professional guidelines governing sterilisation practices.
63. Anecdotal evidence indicates that applications for non-therapeutic sterilisations of women and girls with disabilities in Australia may be on the increase rather than in decline. For example, recent reports



to WWDA suggest that gynaecologists are applying to Guardianship Boards for authorisation to perform hysterectomies on disabled girls as soon as they reach the age of 18 years. It appears that the applications are being sought solely for the purpose of 'prevention of future pregnancy'.<sup>128</sup>

managing menstruation is a medical matter. Dowse & Frohmader (2001) reported that in Australia, there have been no long-term studies into the health effects of long-term hormonal suppression of menstruation on young women although risk factors such as dysfunction of the ovaries and the cardiovascular system have been identified.<sup>132</sup>

## Forced Contraception/Menstrual Suppression

64. The management of menstruation in women with disabilities should be no different to that provided for any other woman. However, in the case of women and girls with intellectual disabilities, there appears to be an assumption that menstruation is a problem that should be overcome by menstrual suppression or elimination of the cycle.<sup>129</sup> Forced contraception through the use of menstrual suppressant drugs (such as Depo-Provera) is a widespread, current practice in Australia, particularly in group homes and other forms of institutional care. It has been justified as a way of reducing the 'burden' on carers who have to 'deal with' managing menstruation of disabled women and girls. It is however, a means of denying basic reproductive rights and is a form of sexual violence.<sup>130</sup>
65. In 1992, the Victorian Intellectual Disability Review Panel submitted a report to the Minister for Community Services on the use of menstrual suppressants in Victorian institutions. A major finding of the Panel was that there had been blanket administration of drugs causing menstrual suppression to women in institutions who did not require this medication for contraceptive purposes and for whom the medication was prescribed without their consent. The purpose of administering the medication was for the ease of management of the menstrual cycle of the women, that is, for the convenience of the staff caring for them. The Panel found that the drugs Depo-Provera and Norethisterone were being used in Victoria without routine gynaecological screening (Law Reform Commission of Western Australia 1994).
66. A 1994 Australian study by Carlson & Wilson,<sup>131</sup> examined menstrual management issues for women with intellectual disabilities. The study found that frequent access to medical advice and an apparent lack of access to advice about educational and environmental management approaches and to practical support, may be reinforcing a perception that

## Deprivation of liberty and restrictive practices

67. Women and girls with disabilities in Australia continue to be subjected to multiple forms and varying degrees of 'deprivation of liberty' and are subjected to unregulated or under-regulated restrictive interventions.<sup>133 134</sup> This is particularly the case for women and girls with intellectual and/or cognitive disabilities, developmental disabilities and those with psychosocial disabilities. A restrictive intervention has been defined as '*any intervention that is used to restrict the rights or freedom of movement of a person with a disability*',<sup>135</sup> and can include practices such as chemical restraint,<sup>136</sup> mechanical restraint,<sup>137</sup> physical restraint,<sup>138</sup> social restraint,<sup>139</sup> seclusion<sup>140</sup>. Such practices are often imposed as a means of coercion, discipline, convenience, or retaliation by staff, family members or others providing support.<sup>141</sup> These practices are not limited to institutions such as group homes, but also occur in educational settings (such as schools), hospitals, residential aged care facilities and other types of institutions (such as hostels, boarding houses, psychiatric/mental health community care facilities, prisons, supported residential facilities).
68. Australian studies of restrictive practices and people with disabilities are limited and publicly available data from government agencies is not easily sourced.<sup>142</sup> However, in Victoria the public record reports that during 2005/06, on average, 28% of residents with intellectual disabilities in accommodation services were subject to restraint and/or seclusion and 23% of clients with intellectual disabilities in respite services were subject to restraint and/or seclusion.<sup>143</sup> The Australian Psychological Society<sup>144</sup> asserts that at least a quarter of all people with an intellectual disability will be subject at some time to some form of restraint, and has called on the Australian Governments to take urgent action to end restrictive practices in the disability sector:

"Vulnerable children and adults with disabilities, some of whom have difficulty even communicating what has happened to them, continue to be exposed to the risks inherent in using restrictive practices, which have in some cases led to death and which are certainly in contravention of their human rights."<sup>145</sup>

69. The Victorian Government has estimated that between 44-80% of people with disabilities who 'show behaviours of concern' are prescribed chemical restraint.<sup>146</sup> No controlled studies exist that evaluate the value of seclusion or restraint in those with 'serious mental illness',<sup>147</sup> although the use of involuntary seclusion and restraint in all forms is an everyday occurrence, particularly in Australia's public acute inpatient facilities.<sup>148</sup> The widespread, systemic problem of restrictive practices and children with disabilities in Australian schools remains ignored and unaddressed by Governments.<sup>149 150 151</sup>
70. There continues to be a myriad of media reports regarding people with disabilities being deprived of their liberty and subjected to restrictive and violent practices. For example, in 2003 mentally and physically disabled children and adults in residential care in Queensland were locked in cages and physically and sexually abused.<sup>152</sup> In 2009, staff of a Queensland Independent Living facility were found guilty of assaulting and depriving disabled children of their liberty. Common practices at the facility included tying children to the toilet; rubbing chilli in their mouths, beating them with fly swatters when they 'misbehaved', taking away prosthetic limbs, substituting bread and butter for meals, washing out resident's mouths with soap; slapping, hitting, humiliating and pulling the hair of residents.<sup>153</sup> When sentencing one of the staff to 150 hours of community service, the judge said it was clear from the evidence that such practices were not only tolerated, but encouraged at the care facility, and that the culture of abuse 'permeated from the top down'.<sup>154</sup> More than eight former staff were charged with more than 130 counts of abuse involving more than 18 former residents. But the number of abuse victims is unknown, with police unable to gather sufficient evidence from some of the more severely disabled former residents to support further charges.<sup>155</sup>

## Forced Electroshock

71. All Australian states and territories have provisions for the 'treatment' of people with mental illnesses without consent.<sup>156</sup> This occurs when the person's illness is believed to impair his or her capacity to understand the need for treatment, or where the person is likely to put themselves or others at risk in some substantial way.<sup>157</sup> Legislation typically allows for involuntary admission to hospital and, in most jurisdictions, pharmacological or other treatments without consent.
72. In most States and Territories of Australia, involuntary electroconvulsive therapy (ECT) requires the approval of the relevant Mental Health Review Tribunal, except in Tasmania (where approvals are made by the Guardianship and Administration Board) and in Victoria, where current legislation allows treating psychiatrists to administer ECT without consent or external review.<sup>158</sup>
73. In 2009-10 the Queensland Mental Health Tribunal scheduled 462 ECT applications in relation to 355 patients. This was 15.5% higher than the previous year. Of these, 98 (21.2%) were applications for patients undergoing emergency ECT.<sup>159</sup> In 2009-10 in NSW, 716 applications were made to the NSW Mental Health Review Tribunal to administer ECT to involuntary patients (455 or 63.5% of the applications involved female patients). Only 20% of the 716 applications included legal representation for the patient. The NSW Mental Health Act 2007 allows for determinations of more than 12 ECT treatments 'if the Tribunal is satisfied that more are justified, having regard to the special circumstances of the case.' In 2009-10, 5.4% of cases were for more than 12 treatments approved.<sup>160</sup>
74. In Victoria in 2009-10, more than 1100 people received electroconvulsive therapy (ECT), in the public mental health system. Of these, 377 (or about one third) were deemed involuntary patients who did not consent to the ECT. Involuntary mental health patients received more than half of the 12,968 ECT sessions administered in the Victorian public psychiatric system in 2009-10.<sup>161</sup> The use of ECT in Victoria's public and private psychiatric services has increased sharply in recent years. In public mental health services, its use has increased by 12% since 2003-04, and private ECT sessions in Victoria have increased by 71% during the

same period.<sup>162</sup> An 2011 investigation into Victoria's mental health system reported that:

'Practices from a previous age appear routine in some hospitals: threatening patients with electroconvulsive therapy (ECT) if they refuse to take medication; locking bathrooms to prevent patients drinking water, which would negate the effect of the ECT; and imposing a form of solitary confinement as punishment for improper behaviour. Such attempts to subdue and control patients are disturbing enough in fiction such as *One Flew Over the Cuckoo's Nest*; they have no place in hospitals in 21st century Australia.'<sup>163</sup>

## Female Genital Mutilation

75. Female genital mutilation (FGM) (also known as female circumcision, female cutting) has been illegal in Australia since the 1990s. Parliaments in every Australian jurisdiction have perceived FGM as warranting legislative regulation. The legislation prohibits a person from performing any type of FGM, defined as including clitoridectomy, excision of any other part of the genitalia, infibulation, and any other mutilation of the genitalia, on a child or an adult.<sup>164</sup> Consequently, even though those aged over 18 years (or 16 years in South Australia) may consent to medical treatment, any medical practitioner administering FGM would commit an offence even if the child or adult consents.<sup>165</sup>
76. There have however, been media reports in recent times of the practice occurring in Australia. In 2010, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) reported that there was '*some evidence to suggest that it [FGM] does happen in certain parts of Australia*'<sup>166</sup> but that the actual numbers are hard to gauge because it is prohibited by legislation and is something that is performed in an underground way. According to Dr Ted Weaver from RANZCOG, '*there have been reports of children being taken to hospital after having the procedure done with complications from that procedure.*' It has also been reported that the Royal Women's Hospital in Melbourne sees between 600 and 700 women each year who have experienced FGM in some form.<sup>167</sup>

*What specific policies/programmes are in place to prevent and address violence against women and girls with disabilities and/or to address harmful practices that can result into disabilities? How do general policies and plans/programmes on violence against women ensure the inclusion of and accessibility by women and girls with disabilities?*

## Government Policies

77. There is a general lack of specific, targeted policies and programs available in Australia to prevent and address the multiple and complex forms of violence against women and girls with disabilities. The recently released *National Plan to Reduce Violence against Women and their Children 2010-2022* (discussed earlier in this paper) does include specific initiatives focused on violence against women with disabilities, and this is a long-overdue and positive step forward. Most States and Territories are currently in the process of developing their own Implementation Plans to give effect to and operationalise the National Plan. These State and Territory Implementation Plans could provide further scope for more targeted initiatives to address violence against women and girls with disabilities at the state, territory, regional and local levels.
78. As part of the *National Plan to Reduce Violence against Women and their Children 2010-2022*, the Australian Government is establishing a National Plan Implementation Panel (NPIP)<sup>168</sup> to provide advice on the implementation of the National Plan. The NPIP will include a number of non-government representatives as part of the overall approach to engaging the community on the National Plan. WWDA has written to the Federal Minister for the Status of Women (Hon Kate Ellis) and to State and Territory Premiers, re-iterating the critical importance of inclusion of women with disabilities in the membership of the NPIP.
79. The *National Disability Strategy* (NDS) was formally endorsed by the Council of Australian Governments (COAG) in February 2011.<sup>169</sup> A key policy priority of the NDS is the right of people with disability to be safe from violence, exploitation and neglect.<sup>170</sup> The NDS acknowledges that women and men with disabilities often face different challenges by reason of their sex,

or experience the same issues in different ways, and therefore need different supports.<sup>171</sup> The success of the NDS will rely heavily on its implementation at the State and Territory levels. Work is currently underway to develop NDS Implementation Plans at the State/ Territory levels and this could provide opportunities for WWDA to advocate for targeted, gendered initiatives around violence prevention.

80. In June 2010, Australia's Sex Discrimination Commissioner,<sup>172</sup> Elizabeth Broderick, released her *Gender Equality Blueprint 2010*.<sup>173</sup> In efforts to address violence against women, the Sex Discrimination Commissioner's Blueprint recommends, amongst other things, that *'the Australian Government should invite the UN Special Rapporteur on Violence Against Women to visit Australia to contribute to independent monitoring of the nation's 'zero tolerance' approach to gender-based violence.'*<sup>174</sup> WWDA understands the Sex Discrimination Commissioner is currently in the process of putting together a proposal for the Special Rapporteur to visit Australia to undertake a study tour. The Australian Human Rights Commission (AHRC) Disability Rights Unit has prioritised *'violence against women with disabilities'* in its 2011-12 Workplan. WWDA continues to receive strong support from the AHRC, including both the Sex Discrimination Commissioner and the Disability Discrimination Commissioner in efforts to progress the rights of women with disabilities to freedom from violence, exploitation and abuse.
81. *Australia's Disability Services Act (1986)*<sup>175</sup> provides for a set of national guiding standards (known as the Disability Services Standards). The Standards are a set of eight principles intended to represent the core elements of a quality disability service in Australia.<sup>176</sup> The Standards have remained essentially unchanged since 1993,<sup>177</sup> and do not contain a Standard on the right to freedom from violence, exploitation, abuse and neglect.<sup>178</sup> However, in recent years, eight jurisdictions have added a standard on *'Protection of human rights and freedom from abuse'* to their own state/territory-based or jurisdictional standards. In reporting against this Standard, funded agencies 'may provide evidence' that staff have the knowledge to 'report criminal activities, abuse and neglect', and can provide 'practical examples of how they act to prevent abuse and neglect'.<sup>179</sup> As a mechanism to prevent and address violence against women and girls with

disabilities, the Disability Services Standards are grossly ineffective. They are un-gendered, they focus only on 'abuse and neglect', they rely on service providers possessing the knowledge of what constitutes violence against women and girls with disabilities, they are essentially adult focused, and are concerned primarily with the collection of quantitative data. For example, a Review of Disability Services in Tasmania in 2008, found that service performance measurement and monitoring was inadequate and that *'current measures are primarily output and process focused and as such do not provide the opportunity to consider the effectiveness of the service system in achieving meaningful outcomes for clients.'*<sup>180</sup>

## Programs

82. In late 2010, the Australian Government launched 1800 RESPECT - the *National Sexual Assault, Domestic Family Violence Counselling Service* for people living in Australia. It provides a 24 hour telephone and online, crisis and trauma counselling service to anyone whose life has been impacted by sexual assault, domestic or family violence. It includes an information and referral service.<sup>181</sup> The 1800 RESPECT Service does not collect data on the numbers of women with disabilities accessing the service unless the woman chooses to disclose that she has a disability. Between the period November 2010-June 2011, there were 7097 individuals who contacted the 1800 RESPECT Service. Of these, sixty-five individuals identified as having a 'physical disability'; seven identified as having an 'intellectual disability' and five individuals identified as having both a physical and intellectual disability. For the period concerned, 4% of overall callers therefore disclosed that they had a disability.<sup>182</sup> Coordinators of the 1800 RESPECT Service acknowledge that these numbers do not provide an accurate reflection of women with disabilities who may be accessing the service, and also under-estimate the numbers of women and girls with disabilities who experience violence.<sup>183</sup> It must also be acknowledged, that it is inherently difficult (and in many cases impossible) for some women with disabilities experiencing, or at risk of violence, to access the 1800 RESPECT Service, due to: their dependence on others (including perpetrator/s); fear of disclosure, fear of consequences (including

retribution), social isolation, place of residence, communication barriers and impairments, lack of support, nature of disability, lack of assertiveness, unquestioning compliance, lack of awareness of rights, lack of access to information about services and support options, and so on.

83. There is evidence of a very small number of localised programs in some States/Territories that are attempting to address the prevention of violence against women with disabilities. For example, the WWILD Sexual Violence Prevention Service<sup>184</sup> is funded by the Queensland Government to work specifically with women with intellectual and/or learning disabilities in Queensland who have experienced or are at risk of sexual assault, violence or exploitation. The Domestic Violence Resource Centre (DVRC)<sup>185</sup> in Victoria, runs education and training programs for family violence service providers. DVRC is currently working on a program to recruit and train women with disabilities to plan and implement 'Disability and Family Violence' training programs for service providers. People With Disabilities Australia (PWD)<sup>186</sup> runs training courses for service providers on *Responding to Sexual Assault of People with Disabilities*,<sup>187</sup> and over the next three years will implement a *Violence Prevention Training Project* for women with intellectual disabilities, and staff that support them.<sup>188</sup> PWD has also been funded to provide *Sexuality and Human Rights Training* in a number of boarding houses in NSW as one measure to address the unacceptably high levels of violence in this form of accommodation.<sup>189</sup> The Women's Centre for Health Matters in the ACT is currently developing a disability awareness training package for domestic violence/crisis service workers to understand and meet the needs of women with disabilities escaping domestic violence.<sup>190</sup>
84. In relation to the prevention of harmful practices such as FGM, the Melbourne Royal Women's Hospital hosts the *Family and Reproductive Rights Education Program* (FARREP) - a Victorian state-wide program which aims to raise awareness among affected communities and health professionals about FGM and build their capacity to effect positive change.<sup>191</sup>

## *How has the participation of women with disabilities in the development of such laws, programmes/policies been ensured?*

85. WWDA's work on the issue of violence against women with disabilities has found that meaningful engagement must be inherent in the key strategies to address violence against them so that their experiences and their views are integral to identifying potential solutions and building successful interventions. However, women with disabilities in Australia have traditionally been excluded from participating in the development of violence prevention laws, policies, programs and services.<sup>192</sup> Although in recent times there have been improvements in consulting with, and including women with disabilities in the development of violence prevention initiatives (particularly at the national level), there remains much to be done in this area.
86. In its 2010 Concluding Comments regarding the Australian Government's implementation of CEDAW, the CEDAW Committee expressed concern at the under-representation of women with disabilities in decision-making positions and the subsequent persistent inequality of their access to education, employment opportunities and health care services. The Committee noted with concern that measures taken to enhance the participation of women with disabilities in public life remains inadequate, and recommended that the Australian Government adopt targeted measures, including temporary special measures with clear time frames, to ensure the equal participation and representation of women with disabilities in public and political life.<sup>193</sup>
87. Research has demonstrated the importance and effectiveness of women's NGO's in addressing the issue of violence against women.<sup>194 195 196</sup> It is also considered critical to involve women fully and to use their experiences of violence - including the complexities that arise from multiple discrimination - as the starting point for developing policies and programs to address violence. The empowerment of women is vital in any framework to tackle violence against women and girls, and this is even more potent for women with disabilities, who have made it clear that empowerment for them comes from speaking



and/or acting in their own interests; the presence of a collectivity and a basis in self-determination; and a discourse of human rights.<sup>197</sup>

88. Organisations and groups of women with disabilities play an essential role in efforts to promote the rights of women and girls with disabilities to freedom from all forms of violence, exploitation and abuse. However, in Australia, the national organisation of and for women with disabilities (WWDA) is poorly funded, receiving a small amount of operational funding each year from the Australian Government. This funding is not sufficient to sustain the work of the organisation, nor allow for growth and expansion. WWDA's current government funding enables the organisation to operate a small one room office and employ one full time worker (Executive Director) and one part-time worker (Finance & Office Manager). The work undertaken by WWDA relies heavily on the goodwill of its members, all of whom are women with disabilities, and who undertake work for WWDA in an unpaid capacity. Of the 8 Australian State/Territory Governments, there is only one (Victoria) which provides operational funding for a disabled women's organisation.<sup>198</sup>
89. The meaningful participation of women with disabilities in the development of violence prevention laws, policies, programs, and services requires Governments to recognise that organisations, groups and networks of women with disabilities must be adequately resourced and supported in order to:
- develop systems and processes whereby women with disabilities can be identified, trained and recruited to act as advocates to improve the human rights of women with disabilities;
  - develop the necessary systems and tools to support women with disabilities to undertake representative and advocacy roles;
  - undertake capacity building to promote women with disabilities' access to positions of leadership and decision-making;
  - research and identify representation, leadership and systemic advocacy opportunities for women with disabilities.
90. As outlined earlier, in more recent times, WWDA has been consulted by Governments on national family violence legislative and policy reforms. However, this inclusion is largely the result of WWDA's consistent and sustained systemic advocacy on the need for inclusion of women with disabilities in advisory and decision-making structures. This work has resulted in tangible outcomes, but continues to be hampered due to inadequate funding and burdensome, bureaucratic processes which create unnecessary work for WWDA and which impact on the capacity of the organisation to concentrate its efforts on its core business of improving the human rights of women with disabilities in Australia.

# PREVENTION AND PROTECTION

*What measures/initiatives are in place to combat negative perceptions, stereotyping and prejudices of women and girls with disabilities in the public and private spheres?*

91. Gender is one of the most important categories of social organisation,<sup>199</sup> yet people with disabilities are often treated as asexual, genderless human beings. This view is borne out in Australian disability policies, which have consistently failed to apply a gender lens. Most have proceeded (and continue to proceed) as though there are a common set of issues - and that men and women experience disability in the same way.<sup>200</sup> Women with disabilities face multiple discriminations and are often more disadvantaged than men with disabilities in similar circumstances. Women with disabilities are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination.<sup>201</sup> Women with disabilities face particular disadvantages in the areas of education, work and employment, family and reproductive rights, health, violence and abuse.
92. Around the world, images of women and girls with disabilities in the mass media are universally negative or absent, and the situation is no different in Australia. If reported in a news or feature story, the disabled girl or woman is usually singled out as an object of pity or charity, or conversely, as a heroine for achieving the ordinary. If portrayed in a fictional or dramatic work, they are often utilised to represent a negative situation or character flaw (weakness, passivity, evil, sickness). Missing in the media are the everyday stories about girls and women with disabilities who are attending schools, participating in active family life, holding down jobs - part of the foreground and background of the rhythm and dynamics of communities all over the world.<sup>202</sup>





93. Although there are some national initiatives of the Australian Government which aim to combat negative attitudes towards people with disabilities,<sup>203</sup> these initiatives are un-gendered. WWDA's experience confirms that biases and stereotypes related to gender can be as pervasive and limiting as for disability. When the two are combined, the effects can be multiplied.<sup>204</sup> Women with disabilities in Australia want options for diversity in relationships, marriage, mothering, control of fertility and reproduction, running a household, caring for children and older family relatives and to live safely, as well as opportunities for employment and further education.<sup>205</sup> Yet they are often stereotyped as passive, asexual, dependent,<sup>206</sup> compliant,<sup>207</sup> sick, child-like, incompetent and helpless,<sup>208</sup> powerless<sup>209</sup> or insecure.<sup>210</sup> Alternatively, women with developmental disabilities in particular may be regarded as overly sexual, creating a fear of profligacy and the reproduction of disabled babies, often a justification for their sterilisation.<sup>211</sup> These perceptions, although very different, often result in women with disabilities being denied the right to participate in decision-making processes that affect their lives, and contribute to the high incidence of violence perpetrated against them.
94. WWDA's concern remains that whilst Australian initiatives to address attitudes towards people with disabilities remain un-gendered, the negative perceptions, stereotyping and prejudices of women and girls with disabilities will prevail.

*What initiatives exist to inform women and girls with disabilities about their rights, including sexual and reproductive health issues? To what extent do these initiatives address also women in institutions?*

## Sexual and reproductive health

95. Reproductive rights and freedoms rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes the right to make decisions regarding reproduction free of discrimination, coercion and violence.<sup>212</sup> For women with disabilities, reproductive

rights and freedoms include the right to bodily integrity, the right to procreate, the right to sexual pleasure and expression, the right for their bodies to develop in a normal way, the right to sex education, to informed consent regarding birth control, to terminate a pregnancy, to choose to be a parent, and to access reproductive information, resources, medical care, services, and support (WWDA 2009).<sup>213</sup>

96. Although the right to 'found a family' and to 'reproductive freedom' is clearly articulated in a number of international human rights instruments to which Australia is a party,<sup>214</sup> for many women with disabilities in Australia, such fundamental human rights are not realisable. Instead, women with disabilities have traditionally been discouraged or denied the opportunity, to bear and raise children.<sup>215</sup> They have been, and continue to be perceived as asexual, dependent, recipients of care rather than care-givers, and generally incapable of looking after children.<sup>216</sup> In Australia, the denial of the right to reproductive freedom and the right to found and maintain a family takes many forms for women with disabilities, including for example: systematic exclusion from comprehensive reproductive and sexual health education and care, limited voluntary contraceptive choices, a focus on menstrual suppression, poorly managed pregnancy and birth, involuntary abortion, forced sterilisation, and the denial of rights to parenting. These practices are framed within traditional social attitudes that characterise disability as a personal tragedy or a matter for medical management and rehabilitation.<sup>217 218</sup>
97. Whilst there are exceptions, there appear to be very few specific, targeted initiatives for women and girls with disabilities in Australia regarding a rights based approach to sexual and reproductive health. Where they exist, the majority of initiatives focusing on disability, sexuality and reproductive rights – are not gendered, focus largely on people with intellectual disabilities, tend to overlook the sexual and reproductive health needs of other women and girls with disabilities, and appear to be primarily targeted at service providers and/or parents and carers.
98. Each State & Territory in Australia has a sexual health and family planning organisation,<sup>219</sup> funded by its respective Government. These organisations can provide information, support and training around

sexuality, relationships, reproductive and sexual health for people with disabilities, as well as those who care for and work with them. Some are more progressive than others in relation to developing specific, targeted initiatives for women and girls with disabilities regarding sexual and reproductive health. For example, some provide disability and gender specific resource materials, yet others do not. Regrettably, much of the online disability resource materials provided by the majority of the Family Planning organisations are only available for download in PDF formats, which remain inaccessible for some women and girls with disabilities. Some provide disability specific training courses for service providers who come into contact with people with disabilities, however Family Planning charges fees for most of these courses.<sup>220</sup> Many of these organisations lack the funding to enable a comprehensive service for women and girls with disabilities.<sup>221</sup>

99. The *SoSAFE! Program* is an example of a sexual and reproductive health program developed in Australia for people with intellectual disabilities. The Program is currently being implemented in the Australian Capital Territory (ACT) and Tasmania, in school, residential and employment settings. The *SoSAFE! Tools* (together with the one day *SoSAFE! Certified Training*) provide teachers, trainers and counsellors with skills and simple visual tools to enhance the social, social-sexual and social safety training of people with 'moderate to severe' intellectual disabilities and Autism Spectrum Disorder.<sup>222</sup> There is no information readily available as to how or whether this Program is being implemented with women and girls with disabilities in institutional settings such as group homes.

100. There are some limited examples of sexual and reproductive health programs developed specifically for women and girls with disabilities. One such Program is the '*Pimples & Periods*' Program, run by Sexual Health & Family Planning (SHFPACT) in the ACT.<sup>223</sup> This Program includes a two hour workshop where girls with a disability and their carers can learn about periods and some of the other changes girls go through physically and emotionally during puberty. Topics include a practical look at managing periods, peer pressure, body image, personal hygiene and the difference between public and private places. The workshops are free, and can be delivered in community settings. SHFPACT's *Schools Disability*

*Program*<sup>224</sup> provides one-to-one education and workshops to people with disabilities, to support positive sexual health choices and strengthen preventative approaches. The Program tailors all education sessions as required, so that students can be supported individually, in small groups or within their integrated class. The Program is free.

101. The Sexuality Education Counselling and Consultancy Agency (SECCA)<sup>225</sup> in Western Australia, provides education and training workshops which are able to be customised. One example is the '*Menstrual Management, Personal Hygiene & Sexual Health*' Training Workshop which aims to '*provide participants with strategies to teach women with a disability, their carers and other health professionals a positive approach to menstruation*'. SECCA also provides a one-on-one specialist counselling and education service in the area of human relationships and sexuality to people who have a disability, their family and significant carers.

## Human Rights Education

102. There are limited examples of targeted programs and other initiatives developed to educate women with disabilities about their human rights generally. In April 2010, the Attorney-General launched Australia's *Human Rights Framework*<sup>226</sup> which outlines a range of key measures to further protect and promote human rights in Australia. Human rights education is the centrepiece of the Framework, and the Australian Government has allocated funding of \$2.068 million over four years to non-government organisations for the development and delivery of human rights community education and engagement programs.<sup>227</sup> Thirty of these NGO projects have been funded to date, and although there are a number that target 'people with disabilities', there are none which are gender and disability specific.<sup>228</sup>

103. A number of Australian disability NGO's are working hard to educate their members and constituents around human rights, however, many lack the funding, resources and capacity to undertake this work effectively. For example, Advocacy for Inclusion,<sup>229</sup> based in the Australian Capital Territory (ACT), delivers self-advocacy courses for women with disabilities, to develop the skills needed to speak for

## PREVENTION AND PROTECTION

themselves. Courses include training around human rights, respectful relationships, self-determination, and assertiveness. WWDA, with limited funding and only two paid staff, relies heavily on its website and use of other information and communication technologies to inform women with disabilities about human rights.

### *What programmes/initiatives have been developed to train women with disabilities to develop skills and abilities for economic autonomy and participation in society and to use technological and other aids that lead to greater independence?*

104. Through organisations like WWDA, and its affiliates, some women with disabilities who do not necessarily see themselves as political actors are able to participate in mobilisation for change through the use of new communication technologies. Through using new media women with disabilities are able to network and engage in mutual learning and support. However, these new technologies are expensive and not always available in remote and rural areas. Many women with disabilities in Australia still do not have access to the Internet. There are issues of affordability, capacity and 'gatekeepers' to technology. It remains a challenge for small organisations such as WWDA to keep abreast of new developments and also to ensure that women with disabilities have access to new forms of interactivity.<sup>230</sup>

105. Women with disabilities are over-represented in low socio-economic groups compared to men with disabilities and women in general. This affects their ability to access Information and Communications Technology (ICT), and further disadvantages them in a range of activities that are now conducted over the Internet. Many E-commerce activities - for example bill paying and banking - offer discounts for business conducted over the Internet. Thus lack of Internet access further penalises people who are already under financial strain. Moreover, the lack of access to the Internet deprives women with disabilities the social interaction afforded by email contact with family, friends, disability support groups and other special interest groups.<sup>231</sup>

106. A national survey undertaken by WWDA in 1999 found that 84% of women with disabilities are restricted in

their access to telecommunications. Forty-nine per cent of responses from women with disabilities cited restrictions due to issues of affordability; 76% due to poor design of telecommunications equipment; 20% due to lack of training; 20% due to lack of information; and 18% due to discrimination.<sup>232</sup> A further study conducted by WWDA in 2000<sup>233</sup> found that the costs of purchasing, operating/maintaining and getting internet connections for a computer were major factors preventing women with disabilities from accessing the Internet. Access to affordable and appropriate training was also a major barrier.

### *What measures exist to ensure access by women and girls with disabilities to social protection programmes and poverty reduction programmes?*

107. Women with disabilities throughout Australia bear a disproportionate burden of poverty and are recognised as amongst the poorest of all groups in society.<sup>234</sup>

108. Although the Australian Government provides a range of income support benefits and payments for people with disabilities,<sup>235</sup> such as the *Disability Support Pension* (DSP), these payments remain inadequate to support women with disabilities. The setting of income support payment rates for women with disabilities has failed to take account of the non-optional, extra costs associated with disability. In 2004, the *Senate Inquiry into Poverty and Financial Hardship*<sup>236</sup> found widespread poverty among people with disabilities. A report released in November 2011 by Price WaterhouseCoopers,<sup>237</sup> found that people with disabilities are more likely to be living in poverty in Australia than any other developed country, they have the worst quality of life in the developed world, and the nation ranks in the bottom third of Organisation for Economic Co-operation and Development (OECD)<sup>238</sup> nations in employing those with a disability (21st out of 29 OECD countries). The report showed there was an employment rate of 39.8 percent for people with disabilities compared with 79.4 per cent for those without a disability.

109. Women with disabilities are less likely to be in paid work (or looking for work) than other women, men with disabilities or the population as a whole. There are fewer employment openings for disabled women

and those who are employed often experience unequal recruitment and promotion criteria, unequal access to training and retraining, unequal access to credit and other production resources, unequal remuneration for equal work and segregation.<sup>239</sup> In Australia, twenty-one per cent (21%) of men with disabilities are in full time employment compared to nine per cent (9%) of women with disabilities.<sup>240</sup> Eleven per cent of women with disabilities have part time employment compared to 6% of men with disabilities.<sup>241</sup> In any type of employment women with disabilities are more likely to be in low paid, part time, short term casual jobs.<sup>242</sup> Over the last decade, the unemployment rate for disabled women in Australia has remained virtually unchanged (8.3%) despite significant decreases in the unemployment rates for disabled men, and non-disabled women and men.<sup>243</sup>

110. In August 2011, following a two year Productivity Commission<sup>244</sup> *Inquiry into the Feasibility of a Long-term Care and Support Scheme for People with Disability* in Australia,<sup>245</sup> the Council of Australian Governments (COAG) agreed on the need for major reform of disability services in Australia through a *National Disability Insurance Scheme* (NDIS) by mid-2013.<sup>246</sup> The NDIS will provide insurance cover for all Australians in the event of 'significant disability'. The main function of the NDIS would be to fund long-term high quality care and support (but not income) for an estimated 410,000 people with 'significant disabilities'. COAG will develop high-level principles by the end of 2011 to guide consideration of the Productivity Commission's recommendations regarding an NDIS,<sup>247</sup> including for foundation reforms, funding and governance.

111. WWDA made a number of Submissions to the Productivity Commission Inquiry into long-term care and support scheme for people with disability in Australia,<sup>248 249</sup> focusing on the need for development of the NDIS to be consistent with Australia's international commitments to 'promote an active and visible policy of mainstreaming a gender perspective into all legislative and policy frameworks'.<sup>250</sup> WWDA's work specifically emphasises the critical need for the NDIS to be gendered, in order to promote equal opportunities for women and girls with disabilities, address gender-based discrimination, and encompass issues for women with disabilities which are critical in the development and implementation of such a

scheme (including for example: sexuality, parenting and reproductive rights; health and wellbeing; employment; and, safety and violence). Regrettably, the Final Report of the Productivity Commission Inquiry, released in August 2011, made no mention of gender, rendering women with disabilities invisible. According to Women With Disabilities Victoria:

"The NDIS will not be effective unless it addresses the specific needs of women with disabilities. We know that all the evidence tells us women with disabilities are the most disadvantaged group in society but once again women with disabilities are invisible in the Productivity Commission's report. As the report stands a mother with a disability will not receive help to bath or feed her children". The next stage of the NDIS must place greater emphasis on recognizing and responding to abuse and violence of people with disabilities; improving services that support women with a disability in their role as parents, and; ensuring women's reproductive and sexual health through appropriate services".<sup>251</sup>

*Please provide information on other measures (legislative, administrative, juridical or other) aimed at the development, advancement and empowerment of women with disabilities.*

112. Political participation and representation are essential markers of gender equality. However, in Australia, women with disabilities are too often excluded from opportunities to participate in decision-making about issues that affect their lives and those of their families, community and nation. It is largely through the actions of women with disabilities themselves that this culture of exclusion is being challenged. Women with disabilities argue that one of the best ways to challenge oppressive practices, cultures and structures is to join with other women with disabilities - to share experiences, to gain strength from one another and to work together on issues that affect them. These collectivities enable women with disabilities to recognise their own needs for personal autonomy, and perhaps more importantly, develop a sense of personal worth. At the broader level, it enables the formation of a collective identity, where women

with disabilities are able to speak out about their experiences together and take action to realise their rights and improve their lives as a group.<sup>252</sup>

113. In Australia, there is an urgent and critical need for governments to establish mechanisms and structures which enable women with disabilities to have their voices heard, and to act politically as agents in their own right. This includes the need to adequately resource, support and strengthen organisations, networks and groups run and controlled by women with disabilities in the pursuit of their collective interests, as defined by them.
114. As outlined earlier in this Paper, in its 46<sup>th</sup> session in 2010, the CEDAW Committee noted with concern that measures taken to enhance the participation of women with disabilities in public life remains inadequate, and recommended that the Australian Government adopt targeted measures, including temporary special measures with clear time frames, to ensure the equal participation and representation of women with disabilities in public and political life.<sup>253</sup>
115. In 2011, the Australian Government announced funding of \$2.9 million over four years for a new national program to help people with disabilities become leaders in business, the community and government through mentoring and leadership development. The 'Leaders for Tomorrow' Program will provide up to 12 months training for around 200 people with disabilities and develop individual leadership development plans for all participants of the program. The Program is not specifically targeted at women with disabilities, although is 'committed to including a variety of participants reflecting the diversity of the Australian community'.<sup>254</sup>
116. Whilst the 'Leaders for Tomorrow' Program is a welcome initiative, women with disabilities in Australia could greatly benefit from a targeted Leadership Development Program for Women and Girls with Disabilities, along the lines of the Indigenous Women's Program, funded by the Australian Government. The Indigenous Women's Program (IWP) is a grants program which provides funding for activities that enhance Indigenous women's leadership, representation, safety, wellbeing and economic status.<sup>255</sup> Amongst other things, the IWP specifically aims to: support more women to

undertake leadership, representative and management roles; and, increase Indigenous women's awareness of, access to, and role in local priority setting and Government funding activities.

*Are there provisions for regular home visits and inspections of medical institutions where women and girls with disabilities are living/ receiving treatment? How do these work?*

117. In Australia, deinstitutionalisation has been heralded as a breakthrough for women with disabilities to provide them with the opportunity to become part of the wider community, especially to those who are able, and who wish to, live by themselves or as autonomously as possible. However, the reality is that while large institutions have been closing, the essential support services for women attempting to integrate into the community have not kept pace with their needs. Consequently, many women with disabilities are forced to live in inappropriate accommodation, where they are vulnerable to violence and abuse. Alternatively, they live without adequate support in the community. They experience considerable difficulties in obtaining relevant information about leaving an institution and finding accommodation elsewhere. The lack of supports available in the community is a major disincentive to women with disabilities to leave institutions.<sup>256</sup>
118. There is no uniform, consistent approach in Australia to protect women and girls with disabilities in institutions from violence, abuse, neglect and exploitation. Women and girls with disabilities in Australia live in a range of settings, including a vast array of different types of 'institutions' such as group homes, residential aged care facilities, hostels, boarding houses, psychiatric/mental health community care facilities, hospitals, prisons, supported residential facilities. Their protection from violence, abuse neglect and exploitation essentially depends on where they live, how or whether the institution is regulated or licenced, and whether or not there are laws, policies, programs and services in existence. For example, some women with disabilities live in boarding houses which may or may not be licenced, some in aged care facilities which again, may or



may not be licenced. However, it remains clear that 'regulations, accreditations, and licencing' do not prevent or even necessarily reduce, violence perpetrated against women with disabilities. This paper, for example, highlights a number of cases where women with disabilities living in government run institutions have experienced multiple forms of violence, which have been either not reported, not investigated, inadequately investigated, remain unsolved, or resulted in poor outcomes for the women concerned.

119. One of the major difficulties in trying to ascertain what protections are in place for women and girls with disabilities living in institutions, is the vast disparity in approaches between the 8 Australian States and Territories. For example, some States/Territories have schemes such as 'Community Visitor Schemes' although, their role and function varies. In Victoria, community visitors are created under three Acts of Parliament,<sup>257</sup> whereby volunteers are empowered by law to visit Victorian accommodation facilities for people with a disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients.<sup>258</sup>
120. In NSW, Official Community Visitors are appointed by the Minister for Disability Services and the Minister for Community Services under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. They visit most government and non-government accommodation services for children, young people and people with a disability throughout NSW. They also visit people living in licensed boarding houses. However, only services that are operated, funded or licensed to provide accommodation and care by the NSW State Government are visited. The Official Community Visitors have the authority to enter and inspect a visitable service without notice.<sup>259</sup> Queensland also has a legislated Community Visitors Program, where 'designated care facilities'<sup>260</sup> can be visited without notice.
121. In South Australia, there is currently no independent community visitor scheme to support people receiving disability services (and monitor the agencies and companies that provide them). There is a Community Visitor Scheme (CVS) established under the SA Mental Health Act 2009, however its

mandate relates to people with a mental illness who are admitted to treatment centres in South Australia. There have been concerns raised about the scheme's transparency and effectiveness, as it operates under the auspices of Government, rather than an independent body (such as the Office of the Public Advocate).<sup>261</sup> There is no legislated Community Visitors Scheme for people with disabilities in Tasmania.

## *What measures have been adopted to provide information and education to women and girls with disability and their families, caregivers and health providers on how to avoid, recognize and report instances of exploitation, violence and abuse?*

122. It is widely acknowledged that at some point in their lives, many women and girls with disabilities will experience, or be at risk of experiencing, violence, abuse, neglect and exploitation. Yet for many, identification and recognition that violence in their lives is a problem or a crime remains a significant issue. They may have difficulties in recognising, defining and describing the violence; have limited awareness of strategies to prevent and manage it; lack the confidence to seek help and support; and be unaware of the services and options available to assist them. The lack of appropriate, available, accessible and affordable services, programs and support has been widely documented in the literature – and borne out by WWDA's experience – as a factor that increases and contributes to violence against women and girls with disabilities.
123. As outlined in other sections of this Paper, to date in Australia, there have been minimal initiatives of any description specifically targeted at women and girls with disabilities in relation to violence, abuse, neglect and exploitation. There is a critical and urgent need for research, data collection, legislative and policy development, advocacy, development of inclusive and accessible services, programs and resources, information and awareness raising, education and training (of both women and girls with disabilities and of service providers across a wide range of sectors), as well as targeted initiatives which foster the social, economic and political empowerment of women



with disabilities. The importance of information and awareness raising, along with education and training of women and girls with disabilities themselves, is particularly urgent.

124. In 1998, WWDA conducted the first ever national 'Workshop on Women With Disabilities and Violence' where women with disabilities from around Australia gathered to develop an agenda for action into the future.<sup>262</sup> In 2007, WWDA received funding from the Australian Government to develop a 'Resource Manual on Violence Against Women With Disabilities'.<sup>263</sup> This Manual is made up of four booklets which include: narratives from women with disabilities who experience violence; a global review of the issue; information about domestic violence and women with disabilities; and a model process for women's refuges and other crisis services to re-orient their practices to be accessible and inclusive. WWDA's Resource Manual has been disseminated to more than two thousand individuals and organisations. In 2008, Women With Disabilities Victoria undertook a state-wide Project on violence against women with disabilities in Victoria. The *Building the Evidence Project*<sup>264</sup> analysed the extent to which current Victorian family violence policy and practice recognises and provides for women with disabilities who experience violence; and makes recommendations to improve responses to women with disabilities dealing with family violence.
125. In 2008, in response to the work of WWDA and Women with Disabilities Victoria, the Victorian Department of Human Services funded and implemented a 'Women with a Disability Family Violence Learning Program'. The aim of the Program was to assist workers in the disability and family violence sectors to provide a more collaborative response to women with a disability who are experiencing family violence. The Program was conducted once in 2008, and was intended to be rolled out across the State, however this has not occurred. The status of the Program is unclear and there is no information available on the effectiveness or outcomes of the one Program that was conducted in 2008.

## What are the means to report violence against women and girls with disabilities in different settings, including medical centres and institutions? To what extent are these known and accessible?

126. As outlined in other sections of this Paper, violence is a significant presence in the lives of large numbers of women and girls with disabilities in Australia, and this situation exists largely due to systemic failures in legislation, policy guidelines, administrative procedures, availability and accessibility of services and support, along with an entrenched culture throughout all levels of society that devalues, stereotypes and discriminates against women and girls with disabilities.
127. As also outlined elsewhere in this Paper, there are a range of mechanisms in Australia to report violence against women and children, including those with disabilities, however, many of these mechanisms remain ineffective for protecting women and girls with disabilities from the multiple forms of violence they experience. For example, the police have a duty to investigate family violence; whether this duty be in legislation or police codes of practice. However, as discussed elsewhere in this paper, police responses to violence perpetrated against women and girls with disabilities remain grossly inadequate.
128. One way that police can be alerted to family violence is through reports from neighbours, health professionals, and others. The making of such reports can be mandated, and persons can be fined for not reporting violence when they should. Such a policy has been adopted in the Northern Territory (NT), where a duty to report some types of family violence is imposed on all adults. Police must take reasonable steps to ensure reports are investigated. Failure to make a report is a criminal offence, and can therefore result in a wide range of persons - including professionals and family members who have not themselves committed family violence - entering into the criminal justice system. As at June 2010, there had been no prosecutions or formal investigations for this offence. Tasmanian family violence legislation also contains a mandatory reporting provision, but the relevant section has not commenced, and the Tasmanian provision, unlike the NT provision, only

applies to 'prescribed persons'. Prescribed persons include registered medical practitioners, nurses, dentists, psychologists, and school teachers.<sup>265</sup>

## *To what extent are public institutions, such as police stations and hospitals, accessible to women and girls with disabilities?*

129. Many public buildings in Australia, including hospitals and police stations, remain inaccessible to people with disabilities.

130. Section 23 of the *Federal Disability Discrimination Act* (DDA) makes it unlawful to discriminate on the grounds of disability in providing access to or use of premises that the public can enter or use. Building access issues also arise under other DDA provisions including in relation to employment, access to services, and accommodation. After more than 10 years of negotiations which the Australian Human Rights Commission (AHRC) initiated, the Australian Government has introduced new standards for access to buildings for people with disabilities. The standards (*Disability (Access to Premises-Buildings) Standards*), approved by the Australian Parliament in November 2010, clarify how to ensure buildings are accessible to people with disabilities and meet the requirements of discrimination law. The completion of this project will ensure that over time buildings in Australia become more accessible, and more useful to an ageing population. More accessible buildings will assist in achieving equal participation for people with disabilities in employment, education, access to services, and other areas of participation in economic, social and cultural life. From May 2011, any new building open to the public, or existing buildings undergoing 'significant renovation', is required to comply with the standards.<sup>266 267</sup>

## *Are there shelters for women victims of violence? To what extent are they physically accessible to women with disabilities?*

131. In June 2010, the United Nations Human Rights Council, urged member states to adopt and implement policies and programmes that enable women to avoid and escape situations of violence and prevent its recurrence, and that provide, financial support and affordable access to safe housing or

shelters, childcare and other social supports, legal assistance, skills training and productive resources, *and to make these services accessible to women and girls with disabilities.*<sup>268</sup>

132. The lack of inclusive services and programs for women with disabilities experiencing or at risk of experiencing violence is well documented.<sup>269 270</sup> There are limited support options for those who do escape violence. Recovering from the trauma of victimisation, and rebuilding their lives as independent, active, valued members of society is a difficult challenge. Where services do exist (such as refuges, shelters, crisis services, emergency housing, legal services, health and medical services, and other violence prevention services) a number of specific issues have been identified<sup>271</sup> which make access for women with disabilities particularly problematic:

- whilst violence is a significant presence in the lives of large numbers of women with disabilities, many do not recognise it as a crime, are unaware of the services and options available to them, and/or lack the confidence to seek help and support.
- experience in community support services suggests that accessible information and communication is very limited in terms of both content and format of information available.
- the physical means of fleeing a violent situation (such as accessible transportation) are often unavailable.
- the low likelihood of being referred to a refuge because it is assumed that such agencies do not or are unable to cater to their needs.

133. Policy makers, service providers and the broader community have limited understandings of accessibility, believing it requires only a ramp or an accessible toilet.<sup>272</sup> In fact accessibility includes being able to receive all policy, service and program information in an accessible format. Experience in Australian health and community support services suggests that this kind of access is extremely limited in terms of both content that reflects the experiences of disabled women and format of information available, such as Braille, audio, Easy English and the use of telephone access relay services and sign interpreters. Another dimension of access includes being able

to understand and meaningfully participate in the services and programs available. Experience suggests that women with disabilities generally have limited input into the development of policies, services and programs, including information and education resources.<sup>273</sup>

134. As outlined earlier in this paper, for several years now, WWDA has been advocating for the Australian Government to commission a national audit of crisis accommodation services (including women's refuges) to determine their levels of accessibility and safety for women with disabilities. In April 2009, the Australian Government agreed that this audit was a priority and committed to consult with the States and Territories to develop a national response to this priority. However, to date, there is no evidence that this has occurred.

135. Research in 2008 undertaken by Women With Disabilities Victoria, found that of Victoria's 23 secure refuge and crisis accommodation, only four described their properties as providing 'full physical access', (which means that there are no steps at the entrance, there is good access inside and accessible bathroom and kitchen facilities). A further five described their properties as having 'limited physical access' (in that there are no major impediments for women with a physical disability, such as internal stairs, but there may be narrow passages in the house that make manoeuvring a wheelchair or frame impossible). The remaining fourteen refuges were located in properties which were described as giving 'no physical access' to women with physical disabilities.<sup>274</sup>

136. Service providers within community support services (such as women's refuges and other crisis services) may share some stereotypes and myths held by society at large regarding women with disabilities.<sup>275</sup> Limitations in workers awareness of the broader issues of accessibility and disabilities, negative or ambivalent attitudes about providing access, lack of knowledge of the complex nature and multiple forms of violence against women with disabilities, limited recognition of the sexuality of women with disabilities, and a tendency to focus on the disability rather than the violence may all stem from this.<sup>276</sup> Resources, attitudes and narrow prescriptions of responsibility are often the reasons for women's services and generic services maintaining exclusionary practices.<sup>277</sup> For example, Women With Disabilities Victoria, in its 2008 'Building

the Evidence Report', gave the example of a family violence worker who said they were doubtful that their management would see supporting women with disabilities as "part of their core business" in providing a family violence service:

"I think there would be great cost implications. I'm not sure that it [referral of women with disabilities] is something we would like to encourage. I feel money, space and other resources would need to be in place if we were going to encourage this type of referral....." <sup>278</sup>

137. Maroondah Halfway House<sup>279</sup> in Victoria is one example of a women's refuge service which is working hard to ensure it is accessible to women with disabilities (and their children). In 2008-09, the service secured funding from the Victorian Government to re-develop part of the refuge into a universal access unit. The unit has two bedrooms, which can each sleep three people, and a separate living area. It can accommodate family or, potentially two single women. It is adjacent to the existing refuge accommodation but has an independent entry point. Since the day it opened, the unit has been fully occupied. Staff have undertaken training in developing Disability Action Plans and have also completed the Domestic Violence Resource Centre (Victoria) '*Getting Safe Against the Odds*' training program on working with women with disabilities.<sup>280</sup>

# PROSECUTION AND PUNISHMENT

## *Are there disaggregated statistics on crimes against persons with disabilities?*

138. There is no data collection in Australia on crimes perpetrated against people with disabilities. The Australian Bureau of Statistics (ABS) produces two key data sources that can inform the community about crime victimisation in Australia. The first of these is a measure of crimes reported to and recorded by police; and the second is a household survey collecting direct reports from members of the public about their experiences of crime.<sup>281</sup> Neither of these sources include data on people with disabilities.

## *Please provide information on the total amount of registered complaints for violence against women and girls with disabilities? Of the total amount how many were dismissed? What were the main reasons for dismissal? Of the cases that were prosecuted, how many resulted in convictions?*

139. Despite high levels of violence against women with disabilities in Australia, few cases are prosecuted. Many cases involving crimes committed against women and girls with disabilities often go unreported, and when they are, they are inadequately investigated, remain unsolved or result in minimal sentences.<sup>282</sup>  
<sup>283</sup> <sup>284</sup> It has been well documented for decades that police are reluctant to investigate and report cases of violence against women with disabilities (particularly women with intellectual, cognitive, developmental, psychosocial disabilities).<sup>285</sup> <sup>286</sup> <sup>287</sup> This is in part due to the stereotypical perceptions of women with disabilities that have been found to be operating at almost all levels of the criminal justice system, including police and courts – ie: that women with disabilities are sexually promiscuous, provocative, unlikely to tell the truth, asexual, childlike, or unable to be a reliable witness.<sup>288</sup> <sup>289</sup> Research has also found



that police are reluctant to investigate allegations made by women with disabilities about violence perpetrated against them by family members and/or carers; and they also fail to act on such allegations because there is no 'alternative to the abusive situation'.<sup>290 291</sup> As recently as November 2011, a Chief Justice of the Supreme Court of Western Australia suggested that the 'biggest problem' in the legal system's fight against domestic violence is the lack of reporting, including the continued 'reluctance of women to report abuse'.<sup>292</sup>

140. Senior public officials in Australia have recently openly acknowledged that police are not investigating cases of rape and serious sexual assault against the disabled because police believe the *'current court system offers no chance of conviction'*.<sup>293</sup> In June 2011, the South Australian Health and Community Services Complaints Commissioner<sup>294</sup> reported that there had been five cases of rape and serious sexual assault against disabled people in the past year and, in the worst case of abuse in care, the victim had become pregnant with the suspected rapist's child but the man had disappeared before any action could be taken against him. None of the five cases resulted in any serious police action because of a lack of corroboration or the extent of the impairment of the alleged victim.<sup>295</sup>

141. In July this year, authorities in South Australia decided not to proceed with a case claiming sexual abuse of a child with an intellectual disability. The prosecution formed the view that the child could not give reliable evidence. The accused was released. Although it transpired that up to 30 other intellectually disabled children had been abused by the accused (a volunteer bus driver with a school for intellectually disabled children) and introduced into a ring of paedophiles,<sup>296</sup> the police and the school authorities did not tell all the parents whose children had come into contact with the accused.<sup>297</sup> It was only as a result of a chance encounter between the parents, that the full extent of their children's abuse was revealed.

142. It often transpires that it is only when cases of alleged abuse against people with disabilities are reported in the media, that some investigative action is pursued by police. For example, in 2006, in a case that shocked the nation, a group of 12 boys all aged under 18, made and sold a DVD depicting the group sexually assaulting

and humiliating a 17-year-old intellectually disabled girl. The girl was forced to perform oral sex on two boys, had her hair set alight three times, was stripped of some of her clothing, was spat at and urinated on during a sustained and degrading assault.<sup>298</sup> The DVD of the assault, entitled *'Cunt: The Movie'* was sold at schools for \$5 and widely distributed throughout the community in Victoria.<sup>299</sup> Segments of the DVD were posted on the popular YouTube website and viewed by more than 9000 people before it was removed from the site due to 'terms of use violation'.<sup>300</sup> Eight of the boys were subsequently charged with assault, manufacturing child pornography and procuring sexual penetration by intimidation. In November 2007, all eight of the boys involved avoided any form of detention, instead being ordered to participate in a rehabilitation program for male adolescents about positive sexuality. Seven had convictions recorded against them. Six were placed on youth supervision orders for between 12 and 18 months and two on probation for 12 months.<sup>301</sup> *'Cunt: The Movie'* remains catalogued on Wikipedia – described as a '2006 Australian movie produced by The Teenage Kings of Werribee'.<sup>302</sup>

143. In 2010, three intellectually disabled women living in accommodation run by the Victorian Department of Human Services were allegedly raped and assaulted after being left alone with a male carer in the state-run house.<sup>303</sup> The mother of one of the women said that her daughter was "covered in bruises" after the alleged attack but did not receive counselling until 10 days later, and even then the women were only given one session of one-on-one counselling.<sup>304</sup> It was only after the media reported the story that the Department of Human Services undertook 'an internal investigation' and police became involved. However, the outcome of the 'internal investigation' is unknown, as is the result of the police investigation. This lack of transparency is a familiar theme in cases of violence and abuse against women and girls with disabilities.

144. In November 2011, it was reported that a major mental health service in Victoria has been covering up sexual assaults of its patients, and that the same service has been previously investigated for allegedly failing to protect an intellectually disabled teenage girl from being sexually exploited by a 34 year old male patient. The latest allegations involved a 20 year old female mental health patient allegedly sexually assaulted by a

male nurse. When the young woman complained to a female staff member, she was told not to tell anyone else about it to avoid it “becoming office gossip”. Police investigated the case but did not lay charges on the grounds it would be difficult to prosecute. An internal investigation was conducted and “appropriate disciplinary action implemented” however, it is not known what disciplinary action was taken, and it has been reported that ‘soon after the alleged incidents’ the male nurse resumed working in mental health services, and ‘remains in a role where he interacts with female patients’.<sup>305</sup> In most jurisdictions in Australia there is no register of perpetrators of violence against people with disabilities in care settings. Consequently, it is relatively easy for perpetrators to move from one place of employment to another when they are discovered or dismissed.<sup>306</sup>

145. The entrenched culture of violence and abuse against people with disabilities in institutions, along with the lack of reporting and cover up by staff and management is acknowledged as a widespread and common problem,<sup>307 308 309</sup> and remains a significant factor in the lack of police investigation, prosecution and conviction of perpetrators. For example, a recent investigation by the Victorian Ombudsman into assault of a disabled client by department-employed carers found that the Victorian Department of Human Services fabricated evidence in an attempt to cover up the assault.<sup>310 311</sup> Similarly, in Tasmania in 2005, an investigation was undertaken into an acute mental health facility after allegations of staff sexual misconduct and concerns about the standard of care and treatment of mental health patients. The investigation by the Tasmanian Health Complaints Commissioner found that management had not adequately addressed the incidents and complaints, and staff who had raised concerns claimed they had been victimised by management as a consequence.<sup>312</sup>

146. An investigation by the NSW Ombudsman in 2011 into residents with psychological and intellectual disabilities living in boarding houses licensed by the state government, found that residents have been physically and sexually assaulted by staff and other residents, have died in appalling circumstances, and been denied basic rights, including contact with their families.<sup>313 314 315</sup> Disturbingly, the report from the investigation is the Ombudsman’s fourth in less than 10 years on the failure of the state to protect boarding

house residents, in particular those with psychological and intellectual disabilities.<sup>316</sup> It was only after significant media coverage and sustained advocacy by the NSW peak organisation for people with disabilities, that police became involved. Forty three residents who had been subjected to significant experiences of abuse and violence were removed from one of the boarding houses under investigation, and police have now established a Taskforce to ‘investigate alleged incidents of assault, attempted suicides, fire and “missing persons” at the state government-licensed boarding house’.<sup>317</sup>

147. Violence perpetrated against women and girls with disabilities by co-residents of institutions, is another grave systemic problem that receives little attention, with cases unlikely to be reported, or adequately investigated and perpetrators prosecuted. For example, in 2009, a severely disabled teenage girl had her nose almost bitten off in a ‘sickening attack’ at a NSW government respite home.<sup>318</sup> The young girl was unable to fend off her 22-year-old male attacker who was in the same facility, despite government policy dictating children should be in separate homes to adults. It was reported that the intellectually disabled man climbed into her bed during the night and tore into her face and chest with his teeth, leaving her with severe bites, black eyes, bruises and scratches all over her body. No charges were laid.<sup>319</sup>

148. It is often the case that violence perpetrated against women and girls with disabilities by co-residents of institutions is rarely characterised as domestic violence and rarely are domestic violence related interventions deployed to deal with this type of violence. Where action is taken at all, the typical response is to move and/or remove the victim rather than the perpetrator, which tends to compound the trauma experienced by the victim.<sup>320</sup> Research also suggests that resident on resident assaults in specialist disability services are ‘typically reframed and detoxified as ‘challenging behaviour’ and the response tends to be one of ‘call for a psychologist’ and adopt behaviour management strategies rather than involve police and protect the victim’.<sup>321</sup>

149. Women and girls with disabilities are socialised or compelled to tolerate a high degree of personal indignity, mishandling, and even violence, abuse, exploitation and neglect as an incident of service



delivery to them. This can lead to their desensitisation to, or to a sense of resignation or despondency about, sexual abuse and other violence,<sup>322</sup> and is a contributing factor to the lack of reporting of violence. Because of the limited recognition of the sexuality of women with disabilities, along with the ignorance around the intersection of gender, disability and violence, there is also a tendency for family members, carers, service providers and other professionals to interpret evidence (such as bodily injuries, verbal or gestural cues, and behaviour) that may be indicative of violence, as a characteristic of impairment or disability.<sup>323 324</sup> This can result in a failure to identify, report and investigate incidents of violence perpetrated against women and girls with disabilities.

150. There are some reported cases where perpetrators of violence against women and girls with disabilities have been brought to justice, however such outcomes are difficult to locate (or publicly unavailable) unless they are reported in the media. For example, in 2010, a father of six was jailed for nine years for sexually abusing his intellectually disabled daughter and prostituting her for money to a group of 'truck-driving mates'.<sup>325 326</sup> The sexual abuse began when the girl was 11 years old and continued for nine years. The court also heard she was raped seven times by a neighbour when she was aged fourteen. The father 'loaned her out to friends' for up to \$300 a time. Police were only able to identify one man who paid for sex with the daughter; he was charged with two counts of entering into an agreement of sex with a child under 18. The outcome of that charge is unknown.

151. In September 2011, a 62 year old South Australian man was sentenced to three and a half years jail for 'persistently sexually exploiting' an intellectually disabled 12 year old girl. Although sentenced to three and a half years jail, the man will be eligible for parole in 21 months, 'because he is the sole carer for his sick wife'.<sup>327</sup>

## What system is in place to ensure legal aid for women and girls with disabilities who have been victims of violence?

152. Australian governments provide some legal aid for people assessed as being least able to afford to

cover the costs of a court appearance. The Federal Attorney-General's Department is responsible for administering funding for the provision of legal aid services for federal law matters through Legal Aid Commissions (LAC),<sup>328</sup> administering a Community Legal Services Program<sup>329</sup> and managing legal aid services for Indigenous Australians.<sup>330</sup> State and territory governments fund legal aid services for cases being tried under state and territory law. There are eight independent legal aid commissions, one in each of the states and territories. Funding is provided by the federal government and state and territory governments. The federal government also funds a network of Family Violence Prevention Legal Services<sup>331</sup> across rural and remote Australia, which provide services specifically to Indigenous victims of family violence and/or sexual assault or abuse. Disability Discrimination Act Legal Services (DDLs) are funded as a component of the Community Legal Services Program. These services operate in each State and Territory of Australia and are funded to address the needs of people experiencing discrimination because of a disability or a perceived disability or because a family member or friend has a disability.<sup>332</sup>

153. Despite the existence of a range of legal services in Australia, it is widely recognised, and borne out by WWDA's experience, that women with disabilities continue to face significant barriers in accessing legal processes and services.<sup>333</sup> Just some examples of barriers include:

- *A lack of awareness of legal rights and options* – many women with disabilities experiencing, or at risk of violence do not realise that what is occurring to them is a criminal offence.<sup>334</sup>  
<sup>335</sup>Whilst violence is a significant presence in the lives of large numbers of women with disabilities, many are unaware of the services and options available to them or lack the confidence to seek help and support.<sup>336</sup>
- *Dependence on others to take action* – some women with disabilities who have experienced violence are simply unable to access legal services or bring their own legal actions because they are totally dependent on others to act on their behalf. Women with severe impairment may be denied the opportunity to participate in court processes

unless a third party can gain standing to bring an action on their behalf;<sup>337</sup>

- *Lack of knowledge of the nature and forms of violence against women with disabilities* – throughout all levels of the legal system, there is a lack of knowledge of the complex nature and multiple forms of violence against women with disabilities, limited recognition of the sexuality of women with disabilities, and a common tendency to focus on the disability rather than the violence;<sup>338</sup>
- *Lack of knowledge about disability* – there is a significant lack of knowledge, expertise and experience within the legal sector about disability generally and the intersection of gender and disability specifically.<sup>339 340</sup> The systemic gender bias in the criminal justice system remains a very real issue.<sup>341</sup> The lack of knowledge of disability is reflected in a myriad of ways, such as: limitations in workers awareness of the broader issues of accessibility and disabilities, negative or ambivalent attitudes about providing access, assumptions about the capacity/incapacity of women with disabilities;<sup>342</sup>
- *Fear of retribution* – this is particularly the case when women with disabilities are dependent upon perpetrator/s of the violence;<sup>343 344</sup>
- *Misconceptions about women with disabilities* – commonly held perceptions of women with disabilities (particularly those with intellectual, cognitive, developmental, psychosocial impairments) reduce the likelihood of incidents of violence being reported, investigated and prosecuted;<sup>345</sup>
- *Affordability and Eligibility* – for many women with disabilities, commercial legal services are simply unaffordable and yet they may be assessed as ineligible for publicly funded legal assistance;<sup>346</sup>
- *Practice Issues* – these can include for example: absence of protocols for dealing with women with disabilities who make complaints; rules of evidence which discriminate against people with disabilities giving evidence; courtroom procedures that unfairly impinge on the rights of people with disabilities; the reliance on formal written

processes; and general lack of access to courts;<sup>347 348</sup>

- *Lack of and under-resourcing of specialist services* – there is an acute lack of specialist legal services for people with disabilities, and where these do exist, they are severely under-resourced.<sup>349</sup> General community legal services do not necessarily have the time, skills, expertise or resources to address the legal needs of women with disabilities experiencing violence, and specialist services often lack the capacity to provide assistance.<sup>350</sup>

154. A 2007 study commissioned by Queensland Advocacy Incorporated (QAI), examined in detail, the barriers to justice for people with disabilities in Queensland. The study found that access to legal services, and the quality of legal services, were two of the most significant barriers to justice for people with disabilities.<sup>351</sup>

## What special measures have been envisaged in legislation and practice for victims and witnesses with disabilities?

155. When researching information on Australian policies and legislation around victims and witnesses with disabilities, one of the most notable findings is the lack of information, including the paucity of research, on the issue. Gudjonsson (2010) has observed that 'England has taken the lead in improving the police interview process and the protection of vulnerable interviewees', although 'there still remains a huge unmet need among vulnerable witnesses with regard to identification and implementation of the special measures'.<sup>352</sup> Australian researchers have recommended that future Australian research should build upon the UK developments and that any policy initiatives in this context should not only adopt contemporary terminology, but also comply with Australia's requirements under the Convention on the Rights of Persons with Disabilities (CRPD) to 'promote appropriate training for those working in the field of administration of justice, including police and prison staff' (Article 13) to ensure effective access to justice for persons with disabilities.<sup>353</sup>

156. In a recent paper on *'Police interviews with vulnerable adult suspects'*<sup>354</sup> Dr Lorana Bartels from the Australian Institute of Criminology, found that the relevant Australian legislation in relation to the special needs of vulnerable persons interviewed by police, revealed 'significant differences in approach', and that there is a need for more comprehensive and compatible legislation. Bartels work gives an overview of the Australian legislation and police policies governing police interviews in circumstances where police deal with vulnerable adults.<sup>355</sup> She found that:

- *the legislation in all jurisdictions except the Northern Territory makes some provision for police to arrange an interpreter where the interviewee's English is limited and some jurisdictions have explicit provisions in relation to foreign nationals. The legislation in New South Wales is the most extensive and makes special provision for a range of vulnerable persons. Queensland's legislation relates to Indigenous people and those of 'impaired capacity', while the Commonwealth provisions are limited to Indigenous people. The issue of protections for vulnerable witnesses is currently being considered by the Tasmania Law Reform Institute and the ACT Government.*

In examining the relevant police policies and manuals, Bartels found that:

- *New South Wales and Tasmania provide detailed instruction to officers in relation to their dealings with vulnerable witnesses and suspects, with such information readily available online. Queensland and Western Australia have some information available publicly and more detailed policies were kindly provided for the purposes of the paper. The Northern Territory also provided copies of its policies, which require the use of an interpreter for suspects and witnesses who give responses not in English. The policy provided by Victoria Police relates to deaf and mute and non-English speaking people and those with a mental disorder or affected by drugs or alcohol, but does not refer to the specific circumstances of Indigenous people.*

157. Bartels suggests that:

*'in evaluating police policies and practices in this area, future research should therefore consider the practical effects of such measures in terms of police training, the management of police interviews and ultimately, the impact on criminal investigations. Key research issues in this context are: to what extent are policies on interviewing vulnerable adults—where they exist—applied in practice? And, does the use of these guidelines actually assist in producing more satisfactory outcomes for all parties?'*<sup>356</sup>

158. In June 2011, the South Australian Attorney-General announced that changes would be made to the *South Australian Evidence Act* (1929) part 34CA, in response to the lack of investigation and prosecution of recent cases of sexual assault against people with disabilities.<sup>357</sup> Part 34CA of the Act placed severe restrictions on the evidence which can be heard in court by the severely disabled and children. The *(South Australia) Evidence (Hearsay Rule Exception) Amendment Bill 2011* was tabled in the South Australian Parliament on 14<sup>th</sup> September 2011, and applies to: *'an alleged victim of a sexual offence who is (a) a young child; or (b) a person who suffers from a mental disability that adversely affects the person's capacity to give a coherent account of the person's experiences or to respond rationally to questions'*.<sup>358</sup>

359

159. The *Independent Third Person's (ITP's) Program*<sup>360</sup> is administered by the Office of the Public Advocate (OPA) in Victoria. ITP's are volunteers who assist people with a cognitive disability or mental illness during interviews, or when giving formal statements to Victoria Police. The person with a cognitive disability or mental illness may be an alleged offender, victim or witness. Victoria Police members are responsible for contacting an ITP. An ITP can also be requested, at any time, by the person with a cognitive disability or mental illness, or someone close to them. The Intellectual Disability Rights Service (IDRS)<sup>361</sup> in New South Wales provides a *Criminal Justice Support Network* which supports people with intellectual disabilities involved in any type of criminal matter. Support is available 24 hours a day, 7 days a week

and includes a court support service (includes legal appointments and other court processes); support at police stations; and support at court for parents with intellectual disability involved in care proceedings. Queensland Advocacy Inc (QAI)<sup>362</sup> provides a Justice Support Program designed to respond to the needs of people with disabilities in the justice and related systems. QAI also provides the *Human Rights Legal Service* (HRLS) which assists persons with impaired capacity who are subject to restrictive practices and involuntary treatment in Queensland. Support includes representing the client or the client's guardian in relevant legal hearings. Despite high demand for the HRLS, it was closed in September 2011 due to lack of funding, and remains closed whilst QAI attempts to source funds to reinstate the service.

## What specific training is conducted for law enforcement and legal personnel on the rights of women and girls with disabilities and effective ways to communicate with them?

160. Disabled women come into contact with the criminal justice system both as victims of crime and as offenders. While the range of risk factors precipitating such contact for these two groups of women is complex and the systemic responses are various, it is often the presence of disability that initially heightens their vulnerability to coming into contact with the police and courts, and which results in their incarceration in the first place. Risk of contact with the criminal justice system has been recognised as particularly heightened for women with intellectual and psychiatric impairments. Becoming the victim of a crime or experiencing incarceration may also be implicated in the production of disability, in particular psychological or psychiatric disorders, including post-traumatic stress disorder.<sup>363</sup> Other areas of this Paper have highlighted the many barriers that women and girls with disabilities face in accessing legal processes and services, and the urgent need for targeted, gendered training for those working at all levels of the criminal justice system, including police and courts.

161. There are limited examples of targeted education and training programs in Australia for law enforcement and legal personnel on the rights of women and girls with disabilities. Most disability awareness training and education programs are un-gendered

and focus on people with intellectual or cognitive disabilities. There are however, some initiatives which can be highlighted. For example, the Queensland-wide WWILD Sexual Violence Prevention Service,<sup>364</sup> provides a 'Disability Training Program Victims of Crime' Program which works with individuals, organisations and systems that have contact, or provide a service to, people with intellectual and developmental disabilities who are victims or witnesses to crime. The NSW Intellectual Disability Rights Service (IDRS) provides a range of programs through its *Criminal Justice Support Network*. One such program is the IDRS tailored *Disability Awareness Training* for local court staff; Sheriff's Officers; Transit Officers; Special Constables and Police.

162. The Queensland Criminal Justice Centre (QCJC)<sup>365</sup> is a government funded resource based website for Queensland's criminal lawyers and other professionals working within the criminal justice system. The primary intention of the site is to provide information that will assist lawyers conduct criminal defences where a relevant disability may be at issue. The QCJC conducts disability awareness training across Queensland for lawyers, police and court volunteers. In 2008 the NSW Attorney Generals Department developed a *Capacity Toolkit*,<sup>366</sup> in response to requests from lawyers, medical professionals, health workers, carers and advocates who required more information about capacity, some general capacity principles and guidelines on assessing a person's capacity to make decisions. The Toolkit applies only to the civil (non-criminal) areas of law. In 2009 the Law Society of NSW developed 'A Practical Guide for Solicitors: When a client's capacity is in doubt'. This resource is a short, practical guide for solicitors on what to do and what resources are available to assist them if they are concerned that their client may lack capacity to give instructions or make their own legal decisions.<sup>367</sup>

# RECOVERY, REHABILITATION AND SOCIAL REINTEGRATION

*What measures (legislative, administrative, social, educational or other) are in place to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of women and girls with disabilities who have been victim of any form of exploitation, violence or abuse?*

163. This paper has highlighted a range of legislative, administrative, social, educational and other mechanisms within Australia which are designed to prevent, address, and respond to, violence against women and their children. This Paper has also highlighted and demonstrated that such mechanisms are woefully inadequate in ensuring the rights of women and girls with disabilities to freedom from violence, exploitation and abuse and to freedom from torture and other cruel, inhuman or degrading treatment or punishment.

164. As highlighted throughout this Paper, there have been, and remain, significant systemic failures in legislation, regulatory frameworks, policy, administrative procedures, availability and accessibility of services and support to prevent and address the epidemic that is violence against women and girls with disabilities. Underlying these systemic failures is an entrenched culture throughout all levels of society that devalues, stereotypes and discriminates against women and girls with disabilities, and invariably perpetuates and legitimises not only the multiple forms of violence perpetrated against them, but also the failure of governments to recognise and take action on the issue.<sup>368</sup>



165. In addressing violence against women with disabilities in Australia, it is not possible to truly move forward without an understanding of the depth and seriousness of past and current violations of the rights of women and girls with disabilities to freedom from violence, exploitation and abuse. WWDA has consistently urged the Australian Government to take leadership in this area by commissioning a National Public Inquiry or Royal Commission into Violence Against People with Disabilities in Australia, both historically and currently.

166. There is no specific legal and institutional framework for the investigation and prosecution of violence against people with disabilities in Australia.<sup>369 370</sup> There is no national co-ordinated strategic framework for the prevention of violence against people with disabilities. As a matter of urgency, and consistent with recommendations from other key Australian disabled people's organisations, the Australian Government should establish and adequately resource an independent, statutory, national protection mechanism for 'vulnerable' adults,<sup>371</sup> where the requirement for mandatory reporting is legislated. The Australian Government, in consultation with people with disabilities, should act immediately to develop and adopt, a gendered National Violence & Disability Prevention Strategy, which includes targeted, gendered initiatives to build capacity of individuals and organisations to prevent violence against people with disabilities and to ensure appropriate responses when it does occur.<sup>372</sup>



# APPENDIX 1 PROJECTS ON VIOLENCE AGAINST WOMEN WITH DISABILITIES 1990-2010

## **STAR Conference on Sterilisation (VIC) (1990)**

This report details the proceedings of a Conference held in Victoria (Australia) for women with intellectual disabilities, parents and workers on the issue of sterilisation. The report includes the voices of women with intellectual disabilities and contains a series of recommendations in the areas of: Women's Issues and Rights; Legal; Health; Information; Education; and, Resources.

<http://www.wwda.org.au/record.htm>

## **Access to services for women with disabilities who are subjected to violence (National) (1993)**

This research project was funded and commissioned by the National Committee on Violence Against Women (1993). The project sought to examine the effectiveness of service delivery to women with disabilities who have been subjected to violence. The study specifically looked at access to police, legal and support services. The major recommendations stemming from the research were detailed under the headings of: Support Groups; Education & Training; Data Collection; Access to Services.

ISBN: 0 644 29597 X



**Reclaiming Our Rights - Access to Existing Police, Legal & Support Services for Women with Disabilities or who are Deaf or Hearing Impaired who are Subject to Violence (NSW) (1995)**

This research project was conducted by the NSW Department for Women in 1995. The aim of the project was to investigate the degree of access women with disabilities have to existing services after they have been assaulted. The recommendations of the research report came from the women involved and key service providers including those in the areas of police, health, community services and the justice system. They are classified in the report under three headings which sum up the needs of women with disabilities and women who are deaf/hearing impaired who have been abused. These headings are: empowerment; access to quality services; advocacy. Report is available from the National Library of Australia.

<http://catalogue.nla.gov.au/Record/1375541>

**Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions (NSW) (1997)**

This research project by Women and Mental Health Inc (NSW) was funded by the NSW Department for Women and the NSW Health Department. The Project relates to one of the most disadvantaged groups of women in the community: those who are disempowered and vulnerable by having a mental illness, and are then sexually abused or exploited within the institution in which they are placed for their own safety. This study is a qualitative, exploratory study of the experiences of women who were abused while they were inpatients in a psychiatric hospital, and of the institutional responses to that abuse. The Project Report, Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions, by Jane Davidson, is available from the National Library of Australia.

<http://catalogue.nla.gov.au/Record/1816439>

**The Sterilisation of Girls and Young Women in Australia - A Legal, Medical and Social Context (National) (1997)**

This report concentrates on the sterilisation of girls and young women. The report poses a range of unanswered and grave questions about the fundamental breach of human rights and well-being of children subject to unauthorised sterilisation procedures. It suggests that a genuine concern for protection of the child's best interests should be about a broader advocacy of the child's interests not simply the narrow legal questions of who should make the decisions and how they should be made. The report suggests that fundamental to the success of protecting and ensuring best interests is the support and cooperation of a broader community of medical practitioners, human service providers, specialist consultants in disability, advocates and others. Any weak link will compromise positive outcomes for the child.

<http://www.wwda.org.au/brady.htm>

**More Than Just A Ramp - A Guide for Women's Refuges to Develop Disability Discrimination Act Action Plans (National) (1997)**

This Project was undertaken by Women With Disabilities Australia (WWDA) in 1997. The Project report includes a discussion and analysis of: gender and disability, and women with disabilities and violence. It discusses the barriers women with disabilities face when accessing domestic violence services. The report provides information on the Disability Discrimination Act (1992) including a discussion on 'discrimination'. The report details step by step how to develop a Disability Discrimination Act Action Plan. The Report was updated in 2007 as part of WWDA's 'Resource Manual on Violence Against Women With Disabilities'.

<http://www.wwda.org.au/vrm2007.htm>

## **Woorara Women's Refuge Disability Action Plan (National/VIC)(1997)**

This Project was undertaken by Women With Disabilities Australia (WWDA) in 1997 in collaboration with Woorara Women's Refuge in Victoria. The report details the project which was to develop a Disability Action Plan for the Woorara Women's Refuge. The report sets the context for the study - providing information about the Disability Discrimination Act (1992) including the legislative requirements. The Project Methodology is outlined, including findings from consultations conducted with women with disabilities as part of the project. The report includes the Action Plan developed with Woorara Women's refuge as part of the project.

**More information available from WWDA. Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)**

## **Domestic Violence and Women with Disability Project (QLD) (1998)**

This small, six-month project was funded by the Queensland Department of Families, Youth and Community Care and conducted by MIMS and Associates. The Project aimed to research and design information resources and strategies for women with disabilities about domestic violence. The research component of the Project involved interviews with 9 women with disabilities and surveys to 68 service providers in the disability and violence sectors. The research findings included: service providers' lack of knowledge and skills about the needs of women with disabilities; inaccessible services; and lack of information and resources for women with disabilities experiencing or at risk of experiencing domestic violence.

**More information available from WWDA. Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)**

## **National Workshop on Violence Against Women With Disabilities (National) (1998)**

In 1998, Women With Disabilities Australia (WWDA) conducted a National Violence Against Women With Disabilities Workshop, the first of its kind in Australia and unique in that it was planned, organised, attended and run by, women with disabilities. This report documents the proceedings of the National Women With Disabilities and Violence Workshop. It contains a wide range of information including: background and context information; articles on the intersection of gender, disability and violence; details on work occurring in Australia on domestic violence generally as well as specific work on the issue of violence against women with disabilities; issues and problems identified by workshop participants requiring action; detailed strategies to address areas such as: Education; Research; Information; Social Action; Networking; Service and Program Planning and Delivery.

**More information available from WWDA. Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)**

## **Making a statement: An exploratory study of barriers facing women with an intellectual disability when making a statement to the police about sexual assault (NSW) (2001)**

This Project was funded by the NSW Department of Corrective Services and conducted by the NSW Intellectual Disability Rights Service (IDRS). In this study, sexual assault workers and members of the New South Wales police service in the greater Sydney area were interviewed to identify the barriers that arise when women with intellectual disability decide to make a statement to police following sexual assault. The study's findings demonstrate a need for greater awareness within the police service of police policies and procedures, and legislation, as well as greater co-operation between the police service and other organisations, which have an impact on the lives of women with intellectual disability.

**More information available from WWDA. Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)**

## **The Sterilisation of Girls and Young Women in Australia: Issues and Progress (National) (2001)**

The Report from this study summarises some developments since the 1997 Report 'The Sterilisation of Girls and Young Women in Australia - A Legal, Medical and Social Context', including responses to it, most notably debate about the numbers of sterilisations being performed. It provides up-to-date information on the number of applications to the Family Court or relevant State Guardianship Tribunals. It is written to contribute to further community discussion in this sensitive area.

<http://www.wwda.org.au/brady2.htm>

## **Moving Forward: Sterilisation and Reproductive Health of Women and Girls with Disabilities (National) (2001)**

In 2001, Women With Disabilities Australia (WWDA) undertook a national project on the sterilisation and reproductive health of women and girls with disabilities. The Project report provides a context for the discussion of sterilisation and reproductive health of women and girls with disabilities. It explores the assumptions made in discussing the issues and examines how they come to manifest themselves in the denial of human rights to bodily integrity and rights to reproductive choice and parenting. It examines the major issues in the debate around sterilisation of girls and women with disabilities and reports on developments both in Australia and internationally. It also outlines significant issues in reproductive health for women with disabilities. The report reflects the experiences and perspectives of women and girls with disabilities in reporting on the National Forum on Sterilisation and Reproductive Health for Women and Girls with Disabilities held in Sydney (Australia) in February 2001.

**More information available from WWDA. Email: [wwda@wwda.org.au](mailto:wwda@wwda.org.au)**

## **Domestic Violence Against Women With Disabilities Project (NSW) (2000-2004)**

The project's aim was to increase access to domestic violence services and support for women with disabilities through training and resource information for health and community workers. The Project was a 4 year project of the Benevolent Society and Macarthur Disability Services, and was funded by the Macarthur Area Assistance Scheme. The Project produced a resource kit entitled: Fabulous femmes: a resource kit: inspiration and resources to improve services for women with disabilities affected by domestic violence.

<http://www.bensoc.org.au/uploads/documents/fabulous-femmes-nov04.pdf>

## **Be Safe Be Sure Project: A Project for Women with Intellectual Disabilities on Safety and Sexuality (NSW) (2002)**

This one year Project was funded by the NSW Department of Urban Affairs and Planning and undertaken in the Western area of Sydney. The Project was an educational project for women with intellectual disabilities in the area of safety and sexuality. The Project also aimed to build partnerships between disability services in the area, mainstream services, Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.

<http://www.wwda.org.au/BeSafeBeSure1.pdf>

## **Violence Against Women With Disabilities Project (VIC) (2002-2003)**

The primary focus of this Project from the Domestic Violence and Incest Resource Centre (DVIRC), was to create partnerships between disability services and services for women experiencing violence, in order to better address the needs of women with disabilities who are marginalised by the service system. The Project took the form of a one year demonstration project in the Western Metropolitan region of Victoria. The Report of the Project 'Triple Disadvantage: Out of sight, Out of mind' details the Project, and includes a series of recommendations.

<http://www.wwda.org.au/triple1.pdf>

## **Sexual Offences Project for Women with Disabilities (VIC) (2003)**

The Sexual Offences Project for Women with Disabilities, conducted in Victoria in 2003, aimed to examine the issues and problems victim/survivors with cognitive impairment experience when reporting sexual assault and proceeding with prosecution in Victoria. The Project found, amongst other things that: the policies and practices of disability service providers and other professionals working with people with disabilities, still often lead to silence and isolation in the name of protection. It also found that as a result of sexual assault, victim/survivors with cognitive impairment are often: not believed when they do report sexual assault; not considered reliable witnesses; and, not considered capable of participating in the justice process. It was decided that victim/survivors would not be directly interviewed. The Project instead invited those people who work with victim/survivors to give case studies that illustrate important issues and experiences when reporting and/or seeking access to justice.

<http://www.wwda.org.au/beyondbelief1.pdf>

## **Silent Voices: Women With Disabilities and Family and Domestic Violence (WA) (2003)**

This research project arose as a result of the widespread experience of women with disabilities, disability and community agencies and the paucity of relevant literature in family and domestic violence. The project was a joint project of People with Disabilities (WA) Inc., the Ethnic Disability Advocacy Centre and the Centre for Social Research, Edith Cowan University, Perth. The objectives for the research were to: document the nature and extent of family and domestic violence against women with disabilities who have accessed services in Western Australia; and identify whether the needs of women with disabilities are being adequately addressed by relevant services.

<http://www.wwda.org.au/cockram2.pdf>

## **Four Corners (ABC TV) 'Walk In Our Shoes': Documentary on Sterilisation (National) (2003)**

In June 2003, the current affairs program Four Corners (ABCTV) broadcast a program entitled 'Walk In Our Shoes'. The program explored the issue of whether, and in what circumstances, disabled women (and men) should be sterilised. In this emotionally compelling documentary, the people at the heart of the sterilisation debate – disabled people, their parents and their carers – speak with remarkable candor about their experiences, frustrations and dilemmas. The transcript of the Program is available from the WWDA website.

<http://www.wwda.org.au/4corners.htm>

## **Looking After Me Project (LAM) (NSW) (2004-2007)**

The Looking After Me Resource Kit is one of the outcomes of the Looking After Me Project (LAM). LAM was an innovative three and a half year project that began in January 2004, funded by Western Sydney Area Assistance Scheme. The project was auspiced by the Penrith Women's Health Centre and focussed on the Penrith Local Government Area. The Kit provides visual aids that can be used when discussing domestic violence issues with women with intellectual disabilities.

[http://www.whnsw.asn.au/Looking\\_After\\_Me/Resource-Looking\\_After\\_Me.htm](http://www.whnsw.asn.au/Looking_After_Me/Resource-Looking_After_Me.htm)

## **Pandora's Box: Hume Region Family Violence and Disability Project (VIC) (2006)**

This Project, auspiced by Women's Health Goulburn North East, aimed to address the barriers faced by women with disabilities in seeking assistance from both the family violence and disability support systems within the Hume region of Victoria. The Project developed a Resource Guide as part of the Project.

[http://www.whealth.com.au/documents/publications/whp-pandora\\_box\\_resource\\_guide.pdf](http://www.whealth.com.au/documents/publications/whp-pandora_box_resource_guide.pdf)

## **Violence Against Women with Disabilities Project (VIC) (2008)**

The Domestic Violence and Incest Resource Centre (DVIRC) undertook a Project on violence against women with disabilities, which resulted in the development of an online resource for women with disabilities, and an online resource for service providers in the family violence and disability sectors.

<http://dvrcv.org.au/Disability/AboutthisSite.htm>

<http://www.dvrcv.org.au/Disability/ServiceProviderGuide.htm>

## **Resource Manual on Violence Against Women With Disabilities (National) (2007)**

This Project was undertaken by Women With Disabilities Australia (WWDA) and culminated in the development of a Resource Manual on Violence Against Women With Disabilities. The Manual is made up of four booklets which include: narratives from women with disabilities who experience violence; a global review of the issue; information about domestic violence and women with disabilities; and a model process for women's refuges and other crisis services to re-orient their practices to be accessible and inclusive. Audio, e-text & Large Print PDF versions of the Booklets are included on a CD-ROM which accompanies the Manual. Braille and DAISY versions are also available on request.

<http://www.wwda.org.au/vrm2007.htm>



## **Building the Evidence Project (VIC) (2008)**

The Building the Evidence Project was undertaken as a research collaboration between the Victorian Women with Disabilities Network Advocacy Information Service, the Alfred Felton Research Program at the University of Melbourne, and the Domestic Violence Resource Centre Victoria. The Project analyses the extent to which current Victorian family violence policy and practice recognises and provides for women with disabilities who experience violence; and makes recommendations to improve responses to women with disabilities dealing with family violence.

<http://www.wdv.org.au/publications.htm#bte>

## **Improving Access to Services for Women from non-English Speaking Backgrounds with Disability Experiencing Violence Project (NSW) (2010)**

This Project was conducted by the Multicultural Disability Advocacy Association of NSW (MDAA) with funding provided by the NSW Premiers Department (Office for Women) and Clubs NSW. The Project worked with women with disabilities from non-English Speaking Backgrounds (NESB), and service providers to improve responses to women from NESB with disability experiencing domestic violence.

<http://www.wwda.org.au/mdaaviol1.pdf>

## **Women With Disabilities Accessing Crisis Services (ACT) (2010)**

The project was a collaboration between Women's Centre for Health Matters (WCHM), the Domestic Violence Crisis Service (DVCS) and Women with Disabilities ACT (WWDACT), and which focussed on increasing the capacity for service providers to support women with a disability escaping domestic and family violence. It was funded by a grant from the Women's Services Network (WESNET). The project aimed at exploring current practices, raising awareness and assisting domestic violence / crisis services in the ACT to become more accessible for women with disabilities by developing a set of best practice principles.

<http://www.wwda.org.au/wwdcrisis1.pdf>

## **Accommodating Violence – Disability and Domestic Violence in Residential Settings Project (NSW) (2010)**

This research study was undertaken by People With Disability Australia (PWD). The project report documents the experience of domestic violence and people with disability, particularly women with disability living in licensed boarding houses. The findings outlined in the Project's report derive from a range of activities, consultations, legislative and policy analysis undertaken in the course of the Disability and Domestic Violence in Residential Settings Project (the DDV project) funded by the NSW Office for Women's Policy for the period June 2009 – July 2010.

<http://www.pwd.org.au/documents/pubs/Accommodating%20Violence%20Report.pdf>

# APPENDIX 2 DEFINITIONS OF 'FAMILY VIOLENCE' IN LEGISLATION

WVDA

## APPENDIX 2

JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
CTH	<i>Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011</i>  (before Senate)	<p><b>4AB Definition of family violence</b> etc.</p> <p>(1) For the purposes of this Act, family violence means violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful.</p> <p>(2) Examples of behaviour that may constitute family violence include (but are not limited to):</p> <ul style="list-style-type: none"> <li>(a) an assault; or</li> <li>(b) a sexual assault or other sexually abusive behaviour; or</li> <li>(c) stalking; or</li> <li>(d) repeated derogatory taunts; or</li> <li>(e) intentionally damaging or destroying property; or</li> <li>(f) intentionally causing death or injury to an animal; or</li> <li>(g) unreasonably denying the family member the financial autonomy that he or she would otherwise have had; or</li> <li>(h) unreasonably withholding financial support needed to meet the reasonable living expenses of the family member, or his or her child, at a time when the family member is entirely or predominantly dependent on the person for financial support; or</li> <li>preventing the family member from making or keeping connections with his or her family, friends or culture; or</li> <li>(j) unlawfully depriving the family member, or any member of the family member's family, of his or her liberty.</li> </ul> <p>(3) For the purposes of this Act, a child is exposed to family violence if the child sees or hears family violence or otherwise experiences the effects of family violence.</p> <p>(4) Examples of situations that may constitute a child being exposed to family violence include (but are not limited to) the child:</p> <ul style="list-style-type: none"> <li>(a) overhearing threats of death or personal injury by a member of the child's family towards another member of the child's family; or</li> <li>(b) seeing or hearing an assault of a member of the child's family by another member of the child's family; or</li> <li>(c) comforting or providing assistance to a member of the child's family who has been assaulted by another member of the child's family; or</li> <li>(d) cleaning up a site after a member of the child's family has intentionally damaged property of another member of the child's family; or</li> <li>(e) being present when police or ambulance officers attend an incident involving the assault of a member of the child's family by another member of the child's family.</li> </ul>	Amends the: <i>Family Law Act 1975</i> to protect children and families at risk of violence or abuse by: prioritising the safety of children in parenting matters; including harmful behaviour in the definitions of 'abuse' and 'family violence'; requiring family consultants, family counsellors, family dispute resolution practitioners and legal practitioners to prioritise the safety of children; placing additional reporting requirements on certain parties to provide evidence to courts; and state and territory child protection authorities participating in family law proceedings where appropriate; and Bankruptcy Act 1966 and Family Law Act 1975 to make technical amendments.

JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
	<i>Family Violence Protection Act 2008</i>	<p><b>s5. Meaning of family violence</b></p> <p>1) For the purposes of this Act, family violence is-</p> <p>(a) behaviour by a person towards a family member of that person if that behaviour-</p> <p>(i) is physically or sexually abusive; or</p> <p>(ii) is emotionally or psychologically abusive; or</p> <p>(iii) is economically abusive; or</p> <p>(iv) is threatening; or</p> <p>(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;</p> <p>or</p> <p>(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).</p> <p>Examples: The following behaviour may constitute a child hearing, witnessing or otherwise being exposed to the effects of behaviour referred to in paragraph (a)-overhearing threats of physical abuse by one family member towards another family member; seeing or hearing an assault of a family member by another family member; comforting or providing assistance to a family member who has been physically abused by another family member; cleaning up a site after a family member has intentionally damaged another family member's property; being present when police officers attend an incident involving physical abuse of a family member by another family member.</p> <p>(2) Without limiting subsection (1), family violence includes the following behaviour-</p> <p>(a) assaulting or causing personal injury to a family member or threatening to do so;</p> <p>(b) sexually assaulting a family member or engaging in another form of sexually coercive behaviour or threatening to engage in such behaviour;</p> <p>(c) intentionally damaging a family member's property, or threatening to do so;</p> <p>(d) unlawfully depriving a family member of the family member's liberty, or threatening to do so;</p> <p>(e) causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the family member to whom the behaviour is directed so as to control, dominate or coerce the family member.</p> <p>(3) To remove doubt, it is declared that behaviour may constitute family violence even if the behaviour would not constitute a criminal offence.</p> <p>s6. of the Act defines economic abuse.</p> <p>s7. of the Act defines emotional or psychological abuse.</p>	<p>Passed by the Victorian Parliament on 12 September 2008. Replaces the Crimes (Family Violence) Act.</p> <p>Empowers the police to issue family violence safety notices which may include the same conditions as a family violence intervention order and last until the application for a family violence intervention order is brought before the court.</p> <p>Broadens the definition of family member to include carers.</p> <p>Broadens the definition of family violence to include economic and emotional abuse.</p> <p>Restricts the ability of self-represented respondents to personally cross-examine the alleged victim in court.</p> <p>Violent partners barred from questioning victims in court.</p> <p>Police will be able to issue safety notices outside court hours, giving them the power to remove violent family members.</p> <p>Allows women and children to remain in the family home following a violent incident while the perpetrator is removed.</p> <p>The Crimes (Family Violence) (Holding Powers) Act 2006 allows police to detain a person suspected of family violence for up to six hours.</p> <p>The Crimes Amendment (Rape) Act 2007 amends provisions applying to sexual offences in Victoria making it easier for witnesses to give evidence in sexual offence trials.</p>

JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
QLD	<i>Domestic and Family Violence Protection Act 1989</i>	<p><b>Section 11 - What is domestic violence</b></p> <p>(1) Domestic violence is any of the following acts that a person commits against another person if a domestic relationship exists between the 2 persons—</p> <p>(a) wilful injury;</p> <p>(b) wilful damage to the other person's property; Example of paragraph (b)—wilfully injuring a defacto's pet</p> <p>(c) intimidation or harassment of the other person; Examples of paragraph (c)—</p> <p>1 following an estranged spouse when the spouse is out in public, either by car or on foot</p> <p>2 positioning oneself outside a relative's residence or place of work</p> <p>3 repeatedly telephoning an ex-boyfriend at home or work without consent (whether during the day or night)</p> <p>4 regularly threatening an aged parent with the withdrawal of informal care if the parent does not sign over the parent's fortnightly pension cheque</p> <p>(d) indecent behaviour to the other person without consent;</p> <p>(e) a threat to commit an act mentioned in paragraphs (a) to (d).</p> <p>(2) The person committing the domestic violence need not personally commit the act or threaten to commit it.</p>	<p>As part of the Queensland Government's responsibility for administering the Domestic and Family Violence Protection Act 1989, a review of the Act is currently underway. The draft <i>Domestic and Family Violence Protection Bill 2011</i> has been gathered to inform the review. The review is expected to be completed in late 2011.</p> <p>Provide for the safety and protection of a person who is in a domestic relationship where violence is committed against them by the other party to the relationship.</p> <p>Achieved by the court making a domestic violence order to protect the person against further violence.</p> <p>Substantial amendments made in 2003 extending the types of make application to a Magistrates' Court.</p> <p>Domestic violence is committed under the Act if it takes place between two people in the following domestic relationships:</p> <ul style="list-style-type: none"> <li>- a spousal relationship;</li> <li>- an intimate personal relationship;</li> <li>- a family relationship; and</li> <li>- an informal care relationship. (see section 11A)</li> </ul>

JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
WA	<i>Acts Amendment (Family and Domestic Violence) Act 2004</i>	<p><b>S6. Meaning of “act of family and domestic violence” and “act of personal violence”</b> (1) In this Act — act of family and domestic violence” means one of the following acts that a person commits against another person with whom he or she is in a family and domestic relationship —</p> <p>(a) assaulting or causing personal injury to the person;</p> <p>(b) kidnapping or depriving the person of his or her liberty;</p> <p>(c)damaging the person’s property, including the injury or death of an animal that is the person’s property;</p> <p>(d) behaving in an ongoing manner that is intimidating, offensive or emotionally abusive towards the person;</p> <p>(e) causing the person or a third person to be pursued — (i) with intent to intimidate the person; or (ii) in a manner that could reasonably be expected to intimidate, and that does in fact intimidate, the person;</p> <p>(f) threatening to commit any act described in paragraphs (a) to (c) against the person.</p> <p>(2) In this Act — “act of personal violence” means one of the following acts that a person commits against another person with whom he or she is not in a family and domestic relationship —</p> <p>(a) assaulting or causing personal injury to the person;</p> <p>(b) kidnapping or depriving the person of his or her liberty;</p> <p>(c) causing the person or a third person to be pursued — (i) with intent to intimidate the person; or (ii) in a manner that could reasonably be expected to intimidate, and that does in fact intimidate, the person;</p> <p>(d) threatening to commit any act described in paragraph (a) or (b) against the person;</p> <p>(e) if the person who commits the act has an imagined personal relationship with the person against whom the act is committed, an act that would constitute an act of family and domestic violence if those persons were in a family and domestic relationship.</p> <p>(3) For the purposes of this Act, a person who procures another person to commit an act of abuse, or part of such an act, is to be taken to have also committed the act himself or herself.</p> <p>(4) In this section — “assaulting” includes — (a) an assault within the meaning of The Criminal Code; and (b) behaving in a manner described in paragraph (a), (b) or (c) of section 319(3) of The Criminal Code;</p> <p>“intimidate” has the same meaning as in section 338D of The Criminal Code ; “kidnapping or depriving the person of his or her liberty ” includes behaving in a manner described in section 332 of The Criminal Code ;“pursue” has the same meaning as in section 338D of The Criminal Code .</p>	<p>Makes important changes to Western Australia’s family violence legislative framework [which mainly consists of the Restraining Order Act 1997, The Criminal Code and the Bail Act 1982].</p> <p>Better protection for direct and indirect victims of domestic violence.</p> <p>Seven major changes to Western Australia’s domestic violence law including:</p> <ul style="list-style-type: none"> <li>- increasing penalties where domestic violence is committed in circumstances of aggravation;</li> <li>- significantly limiting the defences to breaching an order;</li> <li>- making it possible to vary or cancel an interim order as opposed to only a final order;</li> <li>- allowing for a violence restraining order to be granted automatically in some cases;</li> <li>- providing better protection to the interests of children in the court environment;</li> <li>- giving police stronger investigation powers and enabling them to issue on-the-spot temporary restraining orders to immediately remove violence offenders from the home; and</li> <li>- reclassifying the various types of restraining orders to include domestic violence rather than just violence.</li> </ul>



JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
NSW	<i>The Crimes Amendment (Apprehended Violence) Act 2006</i>	<p><b>562A Definitions</b></p> <p>domestic relationship—see section 562B.</p> <p>domestic violence offence means a personal violence offence committed by a person against another person with whom the person who commits the offence has or has had a domestic relationship.</p> <p>personal violence offence means: an offence under, or mentioned in, section 19A, 24, 26, 27, 28, 29, 30, 31, 33, 33A, 35, 35A, 37, 38, 39, 41, 44, 46, 47, 48, 49, 58, 59, 61, 61B, 61C, 61D, 61E, 61I, 61J, 61JA, 61K, 61L, 61M, 61N, 61O, 65A, 66A, 66B, 66C, 66D, 66EA, 80A, 80D, 86, 87, 93G, 93GA, 195, 196, 198, 199, 200 or 562ZG, or an offence of attempting to commit an offence referred to in paragraph (a).</p>	<p>Assented to on 27 October 2006.</p> <p>562E Objects of Division 2 [Apprehended DV orders]</p> <p>(1) The objects of this Division are:</p> <ul style="list-style-type: none"> <li>(a) to ensure the safety and protection of all persons, including children, who experience or witness domestic violence, and</li> <li>(b) to reduce and prevent violence between persons who are in a domestic relationship with each other, and</li> <li>(c) to enact provisions that are consistent with certain principles underlying the Declaration on the Elimination of Violence against Women, and</li> <li>d) to enact provisions that are consistent with the United Nations Convention on the Rights of the Child.</li> </ul> <p>(2) This Division aims to achieve its objects by:</p> <ul style="list-style-type: none"> <li>(a) empowering courts to make apprehended domestic violence orders to protect people from domestic violence, intimidation, stalking and harassment, and</li> <li>(b) ensuring that access to courts is as speedy, inexpensive, safe and simple as is consistent with justice.</li> </ul> <p>(3) In enacting this Division, Parliament recognises:</p> <ul style="list-style-type: none"> <li>(a) that domestic violence, in all its forms, is unacceptable behaviour, and</li> <li>(b) that domestic violence is predominantly perpetrated by men against women and children, and</li> <li>(c) that domestic violence occurs in all sectors of the community, and</li> <li>(d) that domestic violence extends beyond physical violence and may involve the exploitation of power imbalances and patterns of abuse over many years, and</li> <li>(e) that domestic violence occurs in traditional and non-traditional settings, and</li> <li>(f) the particularly vulnerable position of children who are exposed to domestic violence as victims or witnesses, and the impact that such exposure can have on their current and future physical, psychological and emotional well-being, and</li> <li>(g) that domestic violence is best addressed through an integrated framework of prevention and support and, in certain cases, may be the subject of appropriate intervention by the court.</li> </ul>

## APPENDIX 2

JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT
SA	<i>Domestic Violence Act 1994</i>	<p>s4 spells out the grounds for making a domestic violence restraining order and states that a defendant commits domestic violence if:</p> <p>(2)For the purposes of this Act, a defendant commits domestic violence—</p> <p>(a) if the defendant causes personal injury to a member of the defendant's family; or</p> <p>(b) if the defendant causes damage to property of a member of the defendant's family;</p> <p>or if on two or more separate occasions—</p> <p>(i) the defendant follows a family member; or</p> <p>(ii)the defendant loiters outside the place of residence of a family member or some other place frequented by a family member; or</p> <p>(iii) the defendant enters or interferes with property occupied by, or in the possession of, a family member; or</p> <p>(iv) the defendant—</p> <p>(A) gives or sends offensive material to a family member or leaves offensive material where it will be found by, given to, or brought to the attention of a family member; or</p> <p>(B) publishes or transmits offensive material by means of the internet or some other form of electronic communication in such a way that the offensive material will be found by, or brought to the attention of, a family member; or the defendant communicates with a family member, or to others about a family member, by way of mail, telephone (including associated technology), facsimile transmission or the internet or some other form of electronic communication; or</p> <p>(v)the defendant keeps a family member under surveillance; or</p> <p>(vi)the defendant engages in other conduct, so as to reasonably arouse in a family member apprehension or fear of personal injury or damage to property or any significant apprehension or fear.</p>	<p>The South Australian Parliament passed a number of Acts in 2008, namely:</p> <p><i>Criminal Law Consolidation (Rape and Sexual Offences) Amendment Act 2008</i> Reforms many offences, including persistent sexual abuse, unlawful sexual intercourse, incest, and offences with animals. Rape defined more comprehensively, including a continuation of sexual intercourse when consent is withdrawn. Introduces a new offence of compelled sexual activity and defines reckless indifference to consent to sexual acts, as well as consent to sexual activity.</p> <p><i>Statutes Amendment (Evidence) Act 2008</i> Reforms laws about the special arrangements for witnesses giving evidence, particularly from vulnerable witnesses including children and victims of serious offences. Reforms the way witnesses may be questioned, the manner in which judges warn or direct juries about the evidence of children, and restricts access to sensitive material that is to be used as evidence. Enable a victim to read impact statements by pre-recording them or for a representative to read them.</p> <p><i>Victims of Crimes Act 2001</i> Provides for a Commissioner for Victim's Rights. Able to require a public agency or official to consult about steps the agency or official might take to further the interests of victims. After consultation, the Commissioner may recommend that the agency or official issue a written apology to the victim. The Commissioner is required to have regard to the wishes of the victim.</p>
JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT

## APPENDIX 2

TAS	<i>Family Violence Act 2004</i>	<p>s. 7 Family violence In this Act –</p> <p>“family violence” means –</p> <p>(a) any of the following types of conduct committed by a person, directly or indirectly, against that person’s spouse or partner:</p> <p>(i) assault, including sexual assault; (ii) threats, coercion, intimidation or verbal abuse; (iii) abduction; (iv) stalking within the meaning of section 192 of the Criminal Code; (v) attempting or threatening to commit conduct referred to in subparagraph (i), (ii), (iii) or (iv); or</p> <p>(b) any of the following:</p> <p>(i) economic abuse; (ii) emotional abuse or intimidation; (iii) contravening an external family violence order, an interim FVO, an FVO or a PFVO.</p> <p>s8. of the Act defines economic abuse</p> <p>Includes emotional abuse or intimidation</p>	<p>Includes most of the recommendations from <i>Safe at Home: A Criminal Justice Framework for Responding to Family Violence in Tasmania (2003)</i>.</p> <p>Includes non-physical abuse, such as verbal abuse, intimidation, coercion, stalking, threats, abduction, emotional abuse and economic abuse.</p> <p>Inclusion of economic abuse in a definition of family violence was an Australian first.</p> <p>Includes the withholding of financial support, maintenance and money for household expenses.</p> <p>The only Australia domestic violence legislation to include sexual assault in its definition of domestic/family violence.</p> <p>Creates a presumption against bail for alleged perpetrators, requiring the decision-maker to consider the likely effect of release on the safety, wellbeing and interests of the victim or affected child.</p> <p>Safety of victims is a primary concern, should be able to remain in the family home.</p> <p>Increased penalties for breaches of orders.</p> <p>A breach that exposes a child to violence considered an aggravating factor in sentencing.</p> <p>Police mandated to notify the Child Protection services of any children present during an incident of family violence and considered at risk.</p>
JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT

ACT	<i>Domestic Violence and Protection Orders Act 2008</i>	<p><b>s. 13 What is domestic violence?</b></p> <p>(1) For this Act, a person's conduct is domestic violence if it—          (a) causes physical or personal injury to a relevant person; or          (b) causes damage to the property of a relevant person; or          (c) is directed at a relevant person and is a domestic violence offence; or          (d) is a threat, made to a relevant person, to do anything in relation to the relevant person or another relevant person that, if done, would fall under paragraph (a), (b) or (c); or          (e) is harassing or offensive to a relevant person; or          (f) is directed at a pet of a relevant person and is an animal violence offence; or          (g) is a threat, made to a relevant person, to do anything to a pet of the person or another relevant person that, if done, would be an animal violence offence.</p> <p>(2) In this Act: domestic violence offence means an offence against—          (a) section 90 (which is about contravening protection orders); or          (b) a provision mentioned in an item in schedule 1 (Domestic violence offences against other legislation) of an Act mentioned in the item.</p> <p>(3) In this section:          animal violence offence means an offence against any of the following provisions of the Animal Welfare Act 1992:</p> <p>(a) section 7 (Cruelty);          (b) section 7A (Aggravated cruelty);          (c) section 8 (Pain);          (d) section 12 (Administering poison);          (e) section 12A (Laying poison);          (f) section 13 (Electrical devices).</p> <p>offence, other than in relation to the <i>Public Order (Protection of Persons and Property) Act 1971</i> Cth, section 11 (Additional offences on premises in a Territory), includes conduct, engaged in outside the ACT, that would be an offence if it were engaged in within the ACT.          personal injury includes nervous shock.</p> <p>S14 defines personal violence.</p>	<p>Section 6 of the Act outlines the objects of the Act which include:</p> <p>(a) to prevent violence between family members and others who are in a domestic relationship, recognising that domestic violence is a particular form of interpersonal violence that needs a greater level of protective response; and</p> <p>(b) to facilitate the safety and protection of people who fear or experience violence by--          (i) providing a legally enforceable mechanism to prevent violent conduct; and          (ii) allowing for the resolution of conflict without the need to resort to adjudication.</p>
JDN	STATUTE	DEFINITION OF FAMILY VIOLENCE	COMMENT

NT	<i>Domestic and Family Violence Act 2007</i>	<p><b>s5</b> - <i>Domestic violence</i> is any of the following conduct committed by a person against someone with whom the person is in a domestic relationship:</p> <p>(a) <i>conduct causing harm;</i>  <i>Example of harm for paragraph (a)</i>  Sexual or other assault.</p> <p>(b) damaging property, including the injury or death of an animal;</p> <p>(c) intimidation;</p> <p>(d) stalking;</p> <p>(e) economic abuse;</p> <p>(f) attempting or threatening to commit conduct mentioned in paragraphs (a) to (e).</p> <p><i>Note - Under Part 2.2, a DVO may be sought, and made, against a person if the person counsels or procures someone to commit the domestic violence, see section 17</i></p> <p>s.6 of the Act defines intimidation  s.7 of the Act defines stalking  s.8 of the Act defines economic abuse</p>	<p>Replaced the <i>Domestic Violence Act (NT)</i>. Commenced on 1 July 2008.</p> <p>Provides for the protection of people in a domestic relationship against violence.</p> <p>Simplifies the processes associated with domestic violence orders to protect women and children.</p> <p>Defines domestic violence to include economic abuse and intimidation as being explicit grounds for orders, as is violence that impacts on the welfare of a child.</p> <p>Provides for the option for children to apply for a Domestic Violence Order (DVO) on their behalf.</p> <p>Increasing the maximum penalty for breaching a Domestic Violence Order from 6 months to 2 years.</p> <p>Presumption in favour of a DVO applicant, who has children in their care, remaining in the family home.</p> <p>Economic abuse and intimidation being explicit grounds for orders, as is violence that impacts on the welfare of a child.</p> <p>The Northern Territory Government introduced the Victims of Crime Assistance Act 2006 to establish schemes to help victims of violent acts with counselling and financial assistance.</p>
----	--	--	--

# ENDNOTES



1. For more detailed information on Women With Disabilities Australia (WWDA), go to: <http://www.wwda.org.au>
2. See WWDA's *Strategic Plan 2010 – 2015* at: <http://www.wwda.org.au/stratplan.htm>
3. See: Commonwealth of Australia (2009) *A Stronger, Fairer Australia: National Statement on Social Inclusion*. Department of the Prime Minister and Cabinet, Canberra; See also: McClelland, R. in Commonwealth of Australia (2010) *Australia's Human Rights Framework*, Attorney-General's Department, Canberra; See also: Australian Government *Australian Values Statement*, Department of Immigration & Citizenship, available online at: <http://www.immi.gov.au/living-in-australia/values/statement/long/>
4. Women With Disabilities Australia (WWDA)(2011) '*Assessing the situation of women with disabilities in Australia: A human rights approach*'. Available online at: <http://www.wwda.org.au/subs2011.htm>
5. In addition to the forms of violence experienced by women in general, the following also constitute violence against women with disabilities: forced/coerced abortion and sterilisation; forced/coerced psychiatric interventions, involuntary commitment to institutions, forced isolation, physical and chemical restraint; strip searches; deprivation of legal capacity; denial of necessities and purposeful neglect; withholding mobility aids, communication equipment, or medication that the woman uses voluntarily; threats to neglect or kill support or assistive animals; being left in physical discomfort or in embarrassing situations for long periods of time; threats of abandonment by caregivers; violations of privacy; rape and sexual abuse by personal carers, staff and other inmates/residents of institutions.
6. International Network of Women with Disabilities (2011) *Violence Against Women with Disabilities*. Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities, Center for Women Policy Studies.
7. Frohmader, C. & Meekosha, H. [forthcoming] Recognition, respect and rights: Women with disabilities in a globalised world. In *Disability and Social Theory*, Edited by Dan Goodley, Bill Hughes and Lennard Davis, London: Palgrave Macmillan.
8. Women With Disabilities Australia (WWDA) (2007b) '*Forgotten Sisters - A global review of violence against women with disabilities*'. WWDA Resource Manual on Violence Against Women With Disabilities. Published by WWDA, Tasmania, Australia.
9. Healey, L., Howe, K., Humphreys, C., Jennings, C. & Julian, F. (2008) *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. Published by the Victorian Women with Disabilities Network Advocacy Information Service, Melbourne.
10. United Nations General Assembly (2006) *In-depth study on all forms of violence against women*. Report of the Secretary-General. A/61/122/Add.1. New York.
11. UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 24 January 2007, A/RES/61/106.
12. Women With Disabilities Australia (WWDA) (2010) *Women With Disabilities & The Human Right to Health: A Policy Paper*. Available online at: <http://www.wwda.org.au/health2006.htm>
13. In 2010, for example, WWDA undertook a national postcard campaign, urging all politicians to support WWDA's call for the Australian Government to commission and fund a national study on the incidence and prevalence of violence against women with disabilities. Although WWDA received in principle support from many politicians, no action has been taken to date.



14. Women With Disabilities Australia (WWDA) (2007b) OpCit.
15. Women With Disabilities Australia (WWDA) (2010) *Women With Disabilities & The Human Right to Health: A Policy Paper*. Available online at: <http://www.wwda.org.au/health2006.htm>
16. Healey, L. et al (2008) OpCit.
17. Bartels, L. (2010) *Emerging issues in domestic/ family violence research*. Research in Practice Report No. 10, Australian Institute of Criminology, Canberra.
18. Tually, S., Faulkner, D., Cutler, C. & Slatter, M. (2008) 'Women, Domestic and Family Violence and Homelessness: A Synthesis Report'. Prepared for the Office for Women (Australian Government).
19. Murray, S. & Powell, A. (2008) *Sexual assault and adults with a disability: Enabling recognition, disclosure and a just response*. Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, Melbourne.
20. United Nations Human Rights Council, Resolution 14/12: *Accelerating efforts to eliminate all forms of violence against women: ensuring due diligence in prevention*. 23 June 2010, A/HRC/RES/14/12.
21. 'Disabled women vulnerable to abuse: govt.' 9News; Monday Oct 24 2011. Accessed online October 2011 at: <http://news.ninemsn.com.au/national/8364611/disabled-women-vulnerable-to-abuse-govt>
22. Ibid.
23. In its 2006 Concluding Comments on Australia's combined Fourth and Fifth Reports on Implementing CEDAW, the CEDAW Committee expressed its regret at the 'absence of sufficient information and data on women with disabilities', and specifically recommended that 'the State Party to include adequate statistical data and analysis, disaggregated by sex, ethnicity and disability, in its next report so as to provide a full picture of the implementation of all the provisions of the Convention.' See: UN Committee on the Elimination of Discrimination against Women, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Australia*, 3 February 2006, CEDAW/C/AUL/CO/5.
24. UN Committee on the Elimination of Discrimination against Women (CEDAW) (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*, 30 July 2010, CEDAW/C/AUS/CO/7.
25. See: <http://www.abs.gov.au/ausstats/abs@.nsf/lookupMF/B62DEB3AC52A2574CA2568A900139340>
26. See: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>
27. Mulroney, J. (2003) *Australian Statistics on Domestic Violence*. Australian Domestic and Family Violence Clearinghouse Topic Paper. Sydney NSW.
28. Flood, M. (2006) *Violence Against Women and Men in Australia: What the Personal Safety Survey can and can't tell us*. DVIRC Quarterly, Edition 4, Summer 2006. Domestic Violence and Incest Resource Centre (DVIRC), Victoria.
29. Phillips, J. & Park, M. (2004, 2006) *Measuring domestic violence and sexual assault against women: a review of the literature and statistics*. Parliament of Australia Library. Retrieved from <http://www.aph.gov.au/library/INTGUIDE/SP/ViolenceAgainstWomen.htm>
30. Women With Disabilities Australia (WWDA) (2004) *Correspondence to Kerry Flanagan*, Australian Government Office of the Status of Women. May 18, 2004.
31. People With Disability Australia (PWDA) (2004) *Correspondence to Kerry Flanagan*, Australian Government Office of the Status of Women. May 31, 2004.
32. Flanagan, K. (2004) *Correspondence to Women With Disabilities Australia (WWDA) from the Department of the Prime Minister and Cabinet Office of the Status of Women*; 3 June 2004.
33. Ibid.
34. Australian Bureau of Statistics (2010) Personal Safety Survey Advisory Group Meeting (16 July 2010) *Agenda Item 6: Survey content for a 2012 Personal Safety Survey (PSS)*.
35. The National Disability Abuse and Neglect Hotline is an Australia-wide telephone hotline for reporting abuse and neglect of people with disability. Cases of abuse and neglect can include physical, sexual, psychological, legal and civil abuse, restraint and restrictive practices, or financial abuse. It can also include the withholding of care and support which exposes an individual to harm. See: <http://www.disabilityhotline.org/>
36. The Hotline is fully funded by the Australian Government through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and operated by People with Disability Incorporated (PWD), a national peak disability rights and advocacy organisation (see: <http://www.pwd.org.au>).
37. French, P., Dardel, J. & Price-Kelly, S. (2010) *Rights Denied: Towards a National Policy Agenda About Abuse, Neglect & Exploitation of Persons with Cognitive Impairment*. People With Disability Australia (PWD), Sydney, NSW.
38. Ibid.
39. See for example: Attard, M., & Price-Kelly, S. (2010) *Accommodating Violence: The experience of domestic violence of people with disability living in licensed boarding houses*, People with Disability Australia, NSW. Accessed online October 2011 at: <http://www.pwd.org.au/documents/pubs/Accommodating%20Violence%20Report.pdf>
40. Putt, J. & Higgins, K. (1997) *Violence Against Women in Australia: Key Research and Data Issues*. Australian Institute of Criminology, Canberra.

41. New South Wales Department for Women (1996) *Reclaiming Our Rights - Access to Existing Police, Legal & Support Services for Women with Disabilities or who are Deaf or Hearing Impaired who are Subject to Violence*. Prepared by Liz Mulder for the New South Wales Department for Women, Sydney, Australia.
42. Commonwealth of Australia (2009) *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.
43. The six outcome areas were: 1) communities are safe and free from violence; 2) relationships are respectful; 3) services meet the needs of women and their children; 4) responses are just; 5) perpetrators stop their violence; and 6) systems work together effectively (NCRVWC 2009).
44. Commonwealth of Australia (2009) *The National Plan to Reduce Violence against Women: Immediate Government Actions*; April 2009, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.
45. Bartels, L. (2010), OpCit.
46. Commonwealth of Australia (2009) *Background Paper to The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.
47. The National Community Attitudes towards Violence against Women Survey (2009) was conducted with a broad cross-section of the Australian community, with approximately 10,000 people participating. The survey included 16 and 17-year-olds with parental consent, telephone interviews with 2,500 members of the Italian, Greek, Chinese, Vietnamese and Indian communities and face-to-face interviews with 400 Indigenous Australians. The results are compared with an equivalent national survey conducted in 1995 to examine changes in attitudes over time. The Survey Report is available online at: [http://www.vichealth.vic.gov.au/~media/ResourceCentre/PublicationsandResources/NCAS\\_CommunityAttitudes\\_report\\_2010.ashx](http://www.vichealth.vic.gov.au/~media/ResourceCentre/PublicationsandResources/NCAS_CommunityAttitudes_report_2010.ashx)
48. The National Plan is a 12-year strategy endorsed by the Commonwealth and states and territory governments. The National Plan will be driven by a series of four three-year Action Plans. The four Action Plans have been designed as a series to be implemented over 12 years, each building on the other.
49. The National Plan to Reduce Violence against Women and their Children 2010-2022 is available online at: <http://www.fahcsia.gov.au/sa/women/progserv/violence/nationalplan/Pages/default.aspx>
50. Davidson, J. & McNamara, L. (1999) Systems that Silence: lifting the lid on psychiatric institutional sexual abuse. In Breckenridge, J. & Laing, L. (Eds) *Challenging Silence Innovative Responses to Sexual and Domestic Violence*. Allen and Unwin, St Leonards, pp. 86-102.
51. Davidson, J. (1997) *Every Boundary Broken Sexual Abuse of Women Patients in Psychiatric Institutions*. Women and Mental Health Inc: Rozelle, NSW, Australia.
52. Keilty, J., & Connelly, G. (2001) *Making a statement: An exploratory study of barriers facing women with an intellectual disability when making a statement about sexual assault to police*. Disability & Society, Vol. 16, No.2, pp. 273-291.
53. Goodfellow, J. & Camilleri, M. (2003) *Beyond Belief, Beyond Justice: The difficulties for victim/survivors with disabilities when reporting sexual assault and seeking justice*. Final report of Stage One of the Sexual Offences Project. Available online at: <http://www.wwda.org.au/viol2001.htm>
54. Cockram, J. (2003) *Silent Voices: Women With Disabilities and Family and Domestic Violence*. A joint project of People with Disabilities (WA) Inc., the Ethnic Disability Advocacy Centre and the Centre for Social Research, Edith Cowan University, Perth, Australia.
55. Heenan, M., & Murray, S. (2006). *Study of reported rapes in Victoria 2000-2003. Summary research report*. Melbourne: Statewide Steering Committee to Reduce Sexual Assault. Published by the Office of Women's Policy, Department for Victorian Communities.
56. OPA is an independent statutory body established by the Victorian State Government. OPA works to protect and promote the interests, rights and dignity of people with a disability. See: <http://www.publicadvocate.vic.gov.au>
57. Office of the Public Advocate (2010) *Violence against people with cognitive impairments: Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria*. Prepared by Janine Dillon. Available online at: [http://www.publicadvocate.vic.gov.au/file/file/Research/Reports/Violence\\_and\\_disability\\_report\\_August2010.pdf](http://www.publicadvocate.vic.gov.au/file/file/Research/Reports/Violence_and_disability_report_August2010.pdf)
58. 'Law failing to protect disabled in state care'; *The Age Newspaper*, April 24, 2011. Accessed online October 2011 at: <http://www.theage.com.au/victoria/law-failing-to-protect-disabled-in-state-care-20110423-1dse1.html>
59. Attard, M., & Price-Kelly, S., (2010) *Accommodating Violence: The experience of domestic violence of people with disability living in licensed boarding houses*, People with Disability Australia, NSW. Accessed online October 2011 at: <http://www.pwd.org.au/documents/pubs/Accommodating%20Violence%20Report.pdf>
60. Cited in Women With Disabilities Australia (WWDA)(2007b) OpCit.
61. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)(2011) *Program Guideline Suite: Part C: Application Information; Community Action Grants, Stream 1 - Community Projects*. FaHCSIA, Canberra.
62. People with Disability Australia (PWD) will receive \$147,720 over three years to roll out a domestic abuse and neglect training package for its staff and service providers. Montagu Community Living (Tasmania) will receive \$250,000 to deliver its 'Find A Friend, Keep A Friend' project supporting women with disabilities.
63. See: <http://www.1800respect.org.au/>
64. Healey, L. et al (2008) OpCit.
65. Women With Disabilities Australia (WWDA) (2007b) OpCit.
66. Murray, S. & Powell, A. (2008) OpCit.
67. Women With Disabilities Australia (WWDA) (2007b) OpCit.
68. Roeher Institute (1994) *Violence and People with Disabilities: A Review of the Literature*. Prepared by Miriam Ticol of the Roeher Institute for the National Clearinghouse on Family Violence, Health Canada, Ontario.
69. Women With Disabilities Australia (WWDA) (2007b) OpCit.
70. Office of the Public Advocate [Victoria] (2010) *Violence against people with cognitive impairments: Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria*. Prepared by Janine Dillon, OPA, Melbourne.
71. See, for example: Disabled People's International (Australia) Women's Network, 'Summary of Response to Housing Issues for Women with Disabilities' in *Women's Network Newsletter for Women with Disabilities*, 1992, Issue 1; Ludo McFerran, 'Consumer driven services: do-it-yourself research that puts the consumer back in the picture' (1996) 11(3) *National Housing Action* 5-12; Diana Currie, 'Housing Issues for Women With Disabilities', *National Housing Action*, 1996, Vol 11, No 3, pp 20-6.
72. NSW Ombudsman (2004) *Assisting homeless people: the need to improve their access to accommodation and support services: final report arising from an inquiry into access to, and exiting from, the Supported Accommodation Assistance Program*, NSW Ombudsman, Sydney.
73. Dowse, L., Frohmader, C. and Meekosha, H. (2010) Chapter 14: 'Intersectionality: Disabled Women'. In Easta, P. (ed) *Women and the Law in Australia*, Reed International Books Australia.

74. Chung, D., Kennedy, R., O'Brien, B., & Wendt, S. (2001) The Impact of Domestic and Family Violence on Women and Homelessness: Findings from a national research project. In *Out of the Fire: Domestic Violence and Homelessness*. A joint publication of the NSW Women's Refuge Resource Centre, the Domestic Violence and Incest Resource Centre and the Council to Homeless Persons. pp. 21-24.
75. Commonwealth of Australia (2008) *Which Way Home? A new approach to homelessness*. A Green Paper on Homelessness prepared by the Commonwealth as a consultation paper. ISBN 9781 921380 976
76. Women With Disabilities Australia (WWDA) (2009) *Submission to the National Human Rights Consultation*. WWDA, Rosny Park, Tasmania. Available online at: [www.wwda.org.au/subs2006.htm](http://www.wwda.org.au/subs2006.htm)
77. Australian Institute of Health and Welfare; *Specialist Homelessness Services NMDs 2011*; accessed online October 2011 at: <http://meteor.aihw.gov.au/content/index.phtml/itemId/398238>
78. Commonwealth of Australia (2008) *The Road Home: Homelessness White Paper*. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Accessed online October 2011 at: <http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/whitepaper/Documents/default.htm>
79. See: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>
80. See: <http://www.abs.gov.au/census>
81. See: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0>
82. Women With Disabilities Australia (WWDA) (2007b) OpCit.
83. Cited in: Commonwealth of Australia (2009) *Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children*. Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.
84. Cockram, J. (2003) OpCit.
85. Hickman, S. cited in Erwin, P. (2000) *Intimate and caregiver violence against women with disabilities*. Minneapolis: Battered Women's Justice Project-Criminal Justice Office, Minneapolis.
86. Commonwealth of Australia (2004) *Forgotten Australians: a report on Australians who experienced institutional or out-of-home care as children*. Report from the Australian Senate Community Affairs References Committee Inquiry. Parliament House, Canberra.
87. Commonwealth of Australia (2004) Ibid.
88. The Family Law Council is a statutory authority established under section 115 of the Family Law Act 1975 (Family Law Act). Members of the Council are appointed by the Attorney-General in consultation with the Prime Minister and Cabinet.
89. Family Law Council (2009) *Improving responses to family violence in the family law system: An advice on the intersection of family violence and family law issues*. Family Violence Committee, Family Law Council, Canberra.
90. Victorian Health Promotion Foundation (2004) *The health costs of violence: Measuring the burden of disease caused by intimate partner violence - A summary of findings*. Department of Human Services, Melbourne.
91. Ibid.
92. Australian Institute of Health and Welfare (2011) *Aboriginal and Torres Strait Islander people with disability: wellbeing, participation and support*; IHW 45. Canberra: AIHW.
93. Australian Bureau of Statistics (ABS) (2010) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People: Prevalence of Disability*. 4704.0. Accessed online October 2011 at: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter510Oct+2010#CWNIP>
94. The nature of violence from an Indigenous perspective is impacted by numerous systemic factors including dispossession from land and traditional culture, breakdown of community kinship systems, racism and vilification, entrenched poverty, overcrowding and inadequate housing, child removal policies and the loss of traditional Aboriginal female roles, male roles and status. See: Family Law Council (2009) OpCit.
95. Family Law Council (2009) OpCit.
96. Commonwealth of Australia (2009) *The Cost of Violence against Women and their Children*. The National Council to Reduce Violence against Women and their Children; Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.
97. Ibid.
98. Munro, I. (2003) 'Monster' who raped and beat colleague jailed for 16 years. *The Age*, November 7, 2003. Accessed online at: <http://www.theage.com.au/articles/2003/11/06/1068013329595.html?from=storyrhs>
99. Supreme Court of Victoria (2003) *R v Empey* [2003] VSC 422 (6 November 2003). Available online at: <http://www.austlii.edu.au/au/cases/vic/VSC/2003/422.html>
100. Australian Bureau of Statistics (2006) 2006 Personal Safety, Australia (Re-issue) Cat. No. 4906.0.
101. Commonwealth of Australia (2009) *Domestic Violence laws in Australia*. The National Council to Reduce Violence against Women and their Children; Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.

102. Excerpts taken from: Family Law Council (2009) *Improving responses to family violence in the family law system: An advice on the intersection of family violence and family law issues*. Family Violence Committee, Family Law Council, Canberra.
103. Tasmanian Government (2003) *'Safe at Home: A Criminal Justice Framework for Responding to Family Violence in Tasmania'*. Options Paper. Office of the Secretary of the Department of Justice and Industrial Relations (DJIR). Hobart, Tasmania.
104. Women With Disabilities Australia (WWDA) (2004) *Submission to the South Australian Government's Discussion Paper: "Valuing South Australia's Women: Towards A Women's Safety Strategy For South Australia"*. WWDA, Tasmania, Australia.
105. The DDA prohibits discrimination in a range of areas including employment, education, the provision of goods, services and facilities, and access to premises. This Act also makes harassment on the basis of disability illegal and protects friends, relatives and other associates from discrimination because of their connection to someone with a disability.
106. Productivity Commission (2004) *Review of the Disability Discrimination Act 1992*, Report no. 30, Melbourne.
107. A Review of the DDA undertaken by the Productivity Commission in 2004, found that the DDA had been more effective for people with physical disabilities and sight or hearing impairments than it had been for people with other disabilities (such as intellectual disability and mental illness). The DDA had been of limited effect for people with multiple disabilities, people living in institutions, as well as for indigenous Australians, people from Non-English speaking backgrounds, and those living in rural areas. The Review also found that in relation to reducing discrimination, the DDA had been essentially ineffective in the area of employment and of only limited effectiveness in improving access to premises. Access to public transport and education were the areas where the DDA was found to have been 'reasonably effective' in its eleven years of operation at the time of the Review.
108. Women With Disabilities Australia (WWDA) (2009) *Submission to the National Human Rights Consultation*. WWDA, Rosny Park, Tasmania. Available online at: [www.wwda.org.au/subs2006.htm](http://www.wwda.org.au/subs2006.htm)
109. *Discovering Australian Guardianship Law*. See: <http://www.austguardianshiplaw.org/>
110. New South Wales (NSW) Guardianship Tribunal (NSW Guardianship Act 1987); Australian Capital Territory (ACT) Civil and Administrative Tribunal (*Guardianship and Management of Property Act 1991*); Northern Territory Office of Adult Guardianship (*Adult Guardianship Act*); Queensland Civil and Administrative tribunal (*Guardianship and Administration Act 2000*); Guardianship Board of South Australia (*Guardianship and Administration Act 2003*); Tasmanian Guardianship and Administration Board (*Guardianship and Administration Act 1995*); Victorian Civil and Administrative Tribunal (VCAT) (*Guardianship and Administration Act 1986*); Western Australian State Administrative Tribunal (SAT) (*Guardianship and Administration Act 1990*).
111. See for example: *About the South Australian Office of the Public Advocate*. Accessed October 2011 at: [http://www.opa.sa.gov.au/cgi-bin/wf.pl?pid=8&mode=show&folder=../html/documents//01\\_About&file=19-What\\_is\\_the\\_Office\\_of\\_the\\_Public\\_Advocate.html](http://www.opa.sa.gov.au/cgi-bin/wf.pl?pid=8&mode=show&folder=../html/documents//01_About&file=19-What_is_the_Office_of_the_Public_Advocate.html)
112. Haxton, N. (2011) *More protection needed to prevent abuse of the disabled*. ABC PM, July 5, 2011. Accessed online October 2011 at: <http://www.abc.net.au/pm/content/2011/s3261847.htm>
113. Tomazin, F. (2011) *Law failing to protect disabled in state care*. The Age, April 24, 2011; Accessed online October 2011 at: <http://www.theage.com.au/victoria/law-failing-to-protect-disabled-in-state-care-20110423-1dse1.html>
114. VCAT was created on 1 July 1998 and amalgamated 15 boards and tribunals to offer a one stop shop dealing with a range of disputes, providing Victorians with access to a civil justice system which is modern, accessible, efficient and cost effective. VCAT deals with disputes about: purchase and supply of goods; discrimination; domestic building works; guardianship and administration; disability services, health and privacy, mental health; legal profession services; owners corporations; residential tenancies; retail tenancies. For more information see: <http://www.vcat.vic.gov.au>
115. Ibid.
116. Ibid.
117. In Western Australia, Victoria, the Australian Capital Territory and the Northern Territory, the Family Court of Australia and the Federal Magistrates Court have exclusive jurisdiction to decide on sterilisation matters. New South Wales, South Australia, Queensland and Tasmania have conferred concurrent jurisdiction in relation to sterilisation decisions on their respective guardianship tribunals and boards.
118. Standing Committee of Attorneys-General (SCAG) (2004) *Issues Paper on the Non-Therapeutic Sterilisation of Minors with a Decision-Making Disability*. Available online at: [www.wwda.org.au/scagpap1.htm](http://www.wwda.org.au/scagpap1.htm)
119. In: Women With Disabilities Australia (WWDA) (2011) *'Submission to the United Nations Special Rapporteurs regarding forced sterilisation in Australia'*. Available online at: [http://www.wwda.org.au/WWDA\\_Submission\\_SR2011.doc](http://www.wwda.org.au/WWDA_Submission_SR2011.doc) (Word version) or [http://www.wwda.org.au/WWDA\\_Submission\\_SR2011.pdf](http://www.wwda.org.au/WWDA_Submission_SR2011.pdf) (PDF version).
120. Ibid.
121. Ibid.
122. WWDA's Submission was sent to Mr. Shuaib Chalklen (Special Rapporteur on Disability); Mr. Anand Grover (Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health); Ms. Rashida Manjoo (Special Rapporteur on Violence against Women); and Mr. Juan E Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment).
123. Committee on the Elimination of Discrimination against Women (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. CEDAW Forty-sixth session, 12 – 30 July 2010. CEDAW/C/AUS/CO/7. See: <http://www2.ohchr.org/english/bodies/cedaw/cedaws46.htm>
124. In considering Australia's report under Article 44 of the CRC (Fortieth Session), the Committee on the Rights of the Child encouraged Australia to: *'prohibit the sterilisation of children, with or without disabilities'*. United Nations Committee on the Rights of the Child, Fortieth Session, Consideration of Reports Submitted by States Parties under Article 44 of the Convention, Concluding Observations: Australia, CRC/C/15/Add.268, 20 October 2005, paras 45, 46 (e).
125. UN General Assembly Human Rights Council (2011) *Draft report of the Working Group on the Universal Periodic Review: Australia*, 31 January 2011, A/HRC/WG.6/10/L. 8 [para. 86.39]. The final document will be issued under the symbol A/HRC/17/10.
126. Women With Disabilities Australia (WWDA), Human Rights Watch (HRW), Open Society Foundations, & International Disability Alliance (IDA) (2011) *Sterilization of Women and Girls with Disabilities: A Briefing Paper* (November). Available online at: [http://www.wwda.org.au/Sterilization\\_Disability\\_Briefing\\_Paper\\_October2011.doc](http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.doc) (Word version) or [http://www.wwda.org.au/Sterilization\\_Disability\\_Briefing\\_Paper\\_October2011.pdf](http://www.wwda.org.au/Sterilization_Disability_Briefing_Paper_October2011.pdf) (PDF version).
127. For more information about the Global Campaign to Stop Torture in Health Care, go to: <http://www.stoptortureinhealthcare.org/>
128. Personal communication to WWDA, November 25, 2011.
129. Dowse, L. and Frohmader, C. (2001) *Moving Forward: Sterilisation and Reproductive Health of Women and Girls with Disabilities*. Published by Women With Disabilities Australia (WWDA), Tasmania, Australia.



130. Women With Disabilities Australia (WWDA) (2009) *Submission to the National Human Rights Consultation*. WWDA, Rosny Park, Tasmania. Available online at: [www.wwda.org.au/subs2006.htm](http://www.wwda.org.au/subs2006.htm)
131. Carlson, G., & Wilson, J. (1996). Menstrual management and Women who have Intellectual Disabilities: Service Providers and Decision-Making. *Journal Intellectual Developmental Disability* (21), pp. 39-57.
132. Dowse, L. and Frohmader, C. (2001) OpCit.
133. Office of the Public Advocate (2010) *Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper*. Accessed online October 2011 at: <http://www.publicadvocate.vic.gov.au/file/file/Research/Submissions/2010/OPA-Submission-to-VLRC-May-2010.pdf>
134. French, P., Dardel, J. & Price-Kelly, S. (2010) *Rights Denied: Towards a National Policy Agenda About Abuse, Neglect & Exploitation of Persons with Cognitive Impairment*. People With Disability Australia (PWD), Sydney, NSW.
135. Office of the Public Advocate (2010) *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected?* Accessed online October 2011 at: <http://www.publicadvocate.vic.gov.au/file/file/Research/Reports/STOs%20in%20Practice,%20How%20are%20the%20HRs%20of%20People%20Detained%20under%20the%20Disability%20Act%202006%20Protected.pdf>
136. Chemical restraint occurs when medication that is sedative in effect is prescribed and dispensed to control the person's behaviour rather than provide treatment. See in: National Mental Health Consumer & Carer Forum (2009) *Ending Seclusion and Restraint in Australian Mental Health Services*. [www.nmhccf.org.au](http://www.nmhccf.org.au)
137. Mechanical restraint is understood as the use of any device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioural control. See for eg: McVilly, K. (2008). *Physical restraint in disability services: current practices; contemporary concerns and future directions*. A report commissioned by the Office of the Senior Practitioner, Department of Human Services, Victoria, Australia.
138. Physical restraint is defined as the sustained or prolonged use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of another person. See for eg: McVilly, K. (2008) OpCit.
139. Social restraint is recognized to include the use of verbal interactions and/or threats of social or other tangible sanctions, which rely on eliciting fear to moderate a person's behavior. See for eg: McVilly, K. (2008) OpCit.
140. In Australia the definition of seclusion is both legislated and policy driven. Seclusion can be understood as 'the confinement of a person alone at any hour of the day or night in a room, the door(s) and window(s) of which cannot be opened by the person from the inside; or the confinement of a person alone at any hour of the day or night in a room in which the door(s) or window(s) are locked from the outside or their opening is prevented by any other means, such as a person holding the door shut; or where exit from a place is prevented by the presence of another person.
141. Cited in McVilly, K. (2008). OpCit.
142. Ibid.
143. Ibid.
144. The Australian Psychological Society (APS) is the largest professional association for psychologists in Australia, representing over 20,000 members. See: <http://www.psychology.org.au>
145. Australian Psychological Society (May 2011) *Psychologists call for prompt end to restrictive practices in disability sector*. Media Release; May 2011.
146. Department of Human Services (2008) *Positive Solutions in Practice: Chemical Restraint: What every Disability Support Worker needs to know*. Office of the Senior Practitioner, Melbourne.
147. Sailas EES, Fenton M. (2000) *Seclusion and restraint for people with serious mental illnesses*. Cochrane Database of Systematic Reviews 2000, Issue 1. Art. No.: CD001163. DOI: 10.1002/14651858.CD001163.
148. National Mental Health Consumer & Carer Forum (2009) OpCit.
149. See for eg: Australian Broadcasting Corporation (ABC TV) (17/05/2011) 'Hidden shame'; 7.30 Report. Accessed online October 2011 at: <http://www.abc.net.au/7.30/content/2011/s3219518.htm>
150. Martin, L. (March 11, 2010) 'Outrage over Seven Hills West Public School putting autistic children in cage'; Accessed online October 2011 at: <http://www.news.com.au/national/outrage-over-seven-hills-west-public-school-putting-autistic-kids-in-cage/story-e6frfkvr-1225839691640>
151. Brown, D. (2010) 'Autistic kids 'caged' at school.' *The Mercury Newspaper*, September 13, 2010. Accessed: [http://www.themercury.com.au/article/2010/09/13/172495\\_tasmania-news.html](http://www.themercury.com.au/article/2010/09/13/172495_tasmania-news.html)
152. Bottom, B. (2003) The man who wasn't there. *The Bulletin*, December 3, 2003.
153. Dibben, K. (2011) 'Blue card denied to abusive carer.' *The Sunday Mail* (Qld) March 27, 2011. Accessed online October 2011 at: <http://www.couriermail.com.au/news/blue-card-denied-to-abusive-carer/story-e6freomx-1226028747166>

154. Flatley, C. (2009) 'Carer guilty of assaulting disabled kids.' *The Age Newspaper*, September 4, 2009. Accessed online at: <http://news.theage.com.au/breaking-news-national/carers-guilty-of-assaulting-disabled-kids-20090904-fawd.html>
155. Wenham, M. (2006) 'Abused can access \$1m fund.' *The Courier Mail*. November 8, 2006. <http://www.couriermail.com.au/news/queensland/abused-can-access-1m-fund/story-e6freof-111112491139>
156. For a detailed analysis of forced psychiatric interventions and practices, see the *Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)* at: <http://www.chrusp.org>
157. Fitzgerald, P. (2011) 'It's time to move on from ECT's shocking past.' *The Conversation*; 29 September 2011; Accessed online October 2011 at: <http://theconversation.edu.au/its-time-to-move-on-from-ects-shocking-past-3312>
158. Baker, R. & McKenzie, N. (2011) Mental health care inquiry. *The Age*, Accessed online October 2011 at: <http://www.theage.com.au/victoria/mental-health-care-inquiry-20110905-1juji.html>
159. Queensland Government (2010) *Mental Health Review Tribunal Annual Report 2009-10*. Accessed October 2011 at: <http://www.mhrt.qld.gov.au/wp-content/uploads/2010/12/mhrt-annual-Report-2009-10.pdf>
160. NSW Mental Health Review Tribunal (2010) *Annual Report of the Mental Health Review Tribunal*. Accessed online October 2011 at: <http://www.mhrt.nsw.gov.au/mhrt/pdf/AnnualReport200910.pdf>
161. Baker, R. & McKenzie, N. (2011) OpCit.
162. Ibid.
163. The Age Newspaper; *Silence hides shameful neglect of mentally ill*; September 5, 2011; Accessed online October 2011 at: <http://www.theage.com.au/opinion/editorial/silence-hides-shameful-neglect-of-mentally-ill-20110904-1js7t.html>
164. Cited in: Mathews, B. (2011) Female genital mutilation: Australian law, policy and practical challenges for doctors. *Medical Journal of Australia*, 194(3), pp. 139-141.
165. Ibid.
166. Bourke, E. (2010) Female circumcision happening in Australia. *ABC News*, February 06, 2010. Accessed online October 2011 at: <http://www.abc.net.au/news/2010-02-06/female-circumcision-happening-in-australia/2594496>
167. Ibid.
168. See: *UN Secretary General's Database on Violence Against Women*; accessed online October 2011 at: <http://webapps01.un.org/vawdatabase/searchDetail.action?measureId=50830&baseHREF=country&baseHREFId=157>
169. The National Disability Strategy (NDS) outlines a 10-year national policy framework to guide government activity across six key outcome areas and to drive future reforms in mainstream and specialist disability service systems to improve outcomes for people with disability, their families and carers. See: Council of Australian Governments (2010) *2010-2020 National Disability Strategy*. Available online at: <http://www.facs.gov.au/sa/disability/progserv/govint/Pages/nds.aspx>
170. See the National Disability Strategy (NDS) under Outcome Area 2: 'Rights protection, justice and legislation'.
171. National Disability Strategy (NDS) at p.14.
172. The Sex Discrimination Commissioner leads the work of the Australian Human Rights Commission to address gender-based discrimination, sexual harassment and other barriers to gender equality in Australia. See: [www.hreoc.gov.au/sex\\_discrimination/index.html](http://www.hreoc.gov.au/sex_discrimination/index.html)
173. The Blueprint sets out key reforms and recommendations in five priority areas which significantly affect both the public and private lives of women and men in Australia. See: Broderick, E. (2010) *Gender Equality Blueprint 2010*. Australian Human Rights Commission, Sydney.
174. Ibid.
175. The Disability Services Act (1986) provides a legislative and funding framework for a range of disability services. See: [http://www.austlii.edu.au/au/legis/cth/consol\\_act/dsa1986213/](http://www.austlii.edu.au/au/legis/cth/consol_act/dsa1986213/)
176. Meltzer, A., Muir, K. & Dinning, B. (2010) *Report on the consultation data for the revision of the National Standards for Disability Services*. Victorian Department of Human Services, Disability Services Division.
177. The Disability Services Standards and are currently being reviewed as part of the development of a National Quality Framework for Disability Services in Australia. This work however, is not yet complete. More information on the National quality framework for disability services in Australia, is available from the Victorian Department of Human Services website at: <http://www.dhs.vic.gov.au/for-service-providers/disability/service-quality-and-improvement/national-quality-framework-for-disability-services-in-australia>
178. A national consultation undertaken in 2010 as part of the review of the National Disability Standards, found that over 80% of people with a disabilities, families/carers and service providers identified the concepts of 'freedom from abuse' and 'rights and human rights' as missing from the National Standards, and wanted it included in any new national Standards developed. See: Meltzer, A., Muir, K. & Dinning, B. (2010) OpCit.
179. Department of Families, Housing, Community Services & Indigenous Affairs (FaHCSIA) (2011) *Disability Services Standards Self-Assessment Guide*; National Disability Advocacy Program. FaHCSIA, Canberra.
180. KPMG (2008) *Review of Tasmanian Disability Services: Summary Report*; Department of Health and Human Services Tasmania. Accessed on line October 2011 at: [http://www.dhhs.tas.gov.au/\\_\\_\\_data/assets/pdf\\_file/0006/60927/Review\\_of\\_Disability\\_Services-Summary\\_Report.pdf](http://www.dhhs.tas.gov.au/___data/assets/pdf_file/0006/60927/Review_of_Disability_Services-Summary_Report.pdf)
181. 1800RESPECT (1800737732) is the Australian Government's National Sexual Assault, Domestic Family Violence Counselling Service for people living in Australia. See: <http://www.1800respect.org.au>
182. Personal communication between WWDA and 1800 RESPECT co-ordinator, November 27 2011.
183. Ibid.
184. WWILD works with women with intellectual and learning disabilities who have experienced or at risk of experiencing sexual violence or have become a victim of crime. WWILD runs two main programs: *The Sexual Violence Prevention Program* provides support to women with intellectual and learning disabilities aged over 15 who have experienced or are at risk of experiencing sexual violence. The *Victims of Crime Disability Training Program* provides support to people with learning and intellectual disabilities who are a victim of crime and the professionals seeking to support them. See: <http://www.wwild.org>
185. DVRCV is a Registered Training Organisation and a major provider of accredited training and professional development programs for family violence workers and other professionals in Victoria. See: <http://www.dvrcv.org.au>
186. People with Disability Australia Incorporated (PWD) is a national peak disability rights and advocacy organisation. See: <http://www.pwd.org.au>
187. People with Disability Australia Incorporated (PWD) Training Services; See: <http://www.pwd.org.au/training.html>
188. Bleasdale, M. (2011) cited in *'Community organisations to reduce violence against women with disabilities'*; Joint Media Release Hon Kate Ellis & Hon Tanya Plibersek; 24 October 2011. Accessed online November 2011 at: [http://www.kateellis.fahcsia.gov.au/mediareleases/2011/pages/ellis\\_m\\_reduced\\_violence\\_24october2011.aspx](http://www.kateellis.fahcsia.gov.au/mediareleases/2011/pages/ellis_m_reduced_violence_24october2011.aspx)
189. This training covers a number of issues relating to sexuality and relationships, violence, abuse and neglect and the rights of people with disability. The training is delivered separately to men and women living in boarding houses in recognition of the higher incidence of violence that many of the women participating will have experienced, as well as the sensitivity of some of the subject matter. The training is also delivered to staff who support people with disability living in boarding houses.

190. Women's Centre for Health Matters (2011) *Disability Awareness Training for Domestic Violence/Crisis Services*. Accessed online November 2011 at: <http://www.wchm.org.au/Prevention-Of-Violence-Against-Women>
191. See: Royal Women's Hospital Melbourne: *Family and Reproductive Rights Education Program (FARREP)* at: <http://www.thewomens.org.au/FamilyandReproductiveRightsEducationProgramFARREP>
192. Women With Disabilities Australia (WWDA)(2009) *Submission to Inform the Development of the Framework for the National Women's Health Policy*. Available online at: <http://www.wwda.org.au/subs2006.htm>
193. UN Committee on the Elimination of Discrimination against Women (CEDAW) (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*, 30 July 2010, CEDAW/C/AUS/CO/7.
194. Council of Europe (1997) *Final Report of Activities of the EG-S-VI including a Plan of Action for combating violence against women. Group of Specialists for Combating Violence Against Women (EG-S-VI)*.
195. United Nations General Assembly (2006) *In-depth study on all forms of violence against women*. Report of the Secretary-General. A/61/122/Add.1.
196. Women With Disabilities Australia (WWDA) (2007b) OpCit.
197. Women With Disabilities Australia (WWDA) (2008) *Policy Paper: 'The Role of Advocacy in Advancing the Human Rights of Women with Disabilities in Australia'*. Available online at: <http://www.wwda.org.au/subs2006.htm>
198. See: Women With Disabilities Victoria (WDV) at: <http://www.wdv.org.au/>
199. Arnade, S. & Haefner, S. (2006) *Gendering the Draft Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*. Legal background paper. Published by Disabled Peoples' International (DPI), Berlin.
200. Gray, G. (2010 draft) *By Women for Women, the Australian women's health movement and public policy*. (forthcoming).
201. UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights* (Art. 3 of the Covenant), 11 August 2005, E/C.12/2005/4, available at: <http://www.unhcr.org/refworld/docid/43f3067ae.html> [accessed 27 June 2010]
202. Duncan, B. & Berman-Bieler, R. (Eds.) (1998) *'International Leadership Forum for Women With Disabilities Final Report'*; Published by Rehabilitation International; New York, USA.
203. See for example: International Day of People With Disabilities (<http://www.idpwd.com.au>); Prime Ministers National Disability Awards (<http://www.idpwd.com.au/awards>); Ramp Up (<http://www.abc.net.au/rampup>)
204. Women With Disabilities Australia (WWDA) and Women With Disabilities Victoria (WDV)(2011) *Joint Submission in Response to the Productivity Commission's Disability Care and Support Draft Report*. Available online at: <http://www.wwda.org.au/subs2011.htm>
205. Ibid.
206. See for eg: Curry, M. et al (2001) Abuse of women with disabilities: An ecological model and review. *Violence Against Women*, Vol. 7, No. 1.
207. See for eg: Carlson, B. (1997) Mental retardation and domestic violence: An ecological approach to intervention. *Social Work*, Vol.42, No.1.
208. See for eg: Crawford, D. & Ostrove, J. (2003) Representations of Disability and the Interpersonal Relationships of Women with Disabilities. *Women & Therapy*, Vol. 26, No.3/4.
209. See for eg: Chang, J. et al (2003) Helping Women with Disabilities and Domestic Violence: Strategies, Limitations and Challenges of Domestic Violence Programs and Services. *Journal of Women's Health*, Vol.12, No.7.
210. See for eg: Calderbank, R. (2000) Abuse and Disabled People: vulnerability or social indifference? *Disability & Society*, Vol.15, No.3.
211. Women With Disabilities Australia (WWDA) (2007b) Op Cit.
212. UN General Assembly (2000) *Further actions and initiatives to implement the Beijing Declaration and Platform for Action*. Resolution adopted by the General Assembly: S-23/3.A/RES/S-23/3 [para.27].
213. Women With Disabilities Australia (WWDA)(2009) OpCit.
214. See for eg: International Covenant on Economic, Social and Cultural Rights (Article 10); International Covenant on Civil and Political Rights (Article 23); Convention on the Elimination of All Forms of Discrimination against Women (Article 16); Convention on the Rights of Persons with Disabilities (Article 23).
215. Women With Disabilities Australia: *'Parenting Issues for Women with Disabilities in Australia' - A Policy Paper* (May 2009). Available at: [www.wwda.org.au/motherhd2006.htm](http://www.wwda.org.au/motherhd2006.htm)
216. Ibid.
217. Ibid.
218. Dowse, L. & Frohmader, C. (2001) *Moving Forward: Sterilisation and Reproductive Health of Women and Girls with Disabilities*, A Report on the National Project conducted by Women with Disabilities Australia (WWDA), Canberra.
219. For links to each State and Territory Family Planning & Sexual Health organisation, go to: <http://www.shfpa.org.au/>



220. See for example: Family Planning NSW Education & Training: [http://fpnsw.org.au/topic\\_education.html?ID=49&TYPE=QUEUE&KEYWORD=&AUDIENCE=4469736162696C69747920576F726B657273&COURSES=&BYDSND=1CONV.POSTED](http://fpnsw.org.au/topic_education.html?ID=49&TYPE=QUEUE&KEYWORD=&AUDIENCE=4469736162696C69747920576F726B657273&COURSES=&BYDSND=1CONV.POSTED)
221. For example, Family Planning Tasmania has one part time worker in its southern region (servicing a population of more than 200,000 people) to undertake both individual 'casework' and all education and training of people with disabilities and as well as those who care for and work with them.
222. SoSAFE! uses a standardised framework of symbols, visual teaching tools and concepts to teach strategies for moving into intimate relationships in a safe and measured manner, and provides visual communication tools for reporting physical or sexual abuse. For more information go to: [http://www.shfpact.org.au/index.php?option=com\\_content&view=article&id=141&Itemid=128](http://www.shfpact.org.au/index.php?option=com_content&view=article&id=141&Itemid=128)
223. Sexual Health & Family Planning ACT (SHFPACT) is a not-for-profit, non-government, membership-based organisation. Its purpose is improved sexual and reproductive health for the Canberra community, within a framework of feminist social values. See: <http://www.shfpact.org.au>
224. Sexual Health & Family Planning ACT (SHFPACT) Schools Disability Program, See: [http://www.shfpact.org.au/index.php?option=com\\_content&view=article&id=39&Itemid=80](http://www.shfpact.org.au/index.php?option=com_content&view=article&id=39&Itemid=80)
225. SECCA is a non-profit organization designed to support people with disabilities, in their efforts to learn about human relationships, sexuality and sexual health across the lifespan; as well as helping them to develop skills that will empower them to make informed choices, while acknowledging their own individual capacity to enhance the quality of their lives. See: <http://secca.org.au/>
226. A copy of *Australia's Human Rights Framework* is available in PDF and Word formats at: <http://www.ag.gov.au/humanrightsframework>
227. Australian Government, Attorney-General's Department; Australia's Human Rights Framework, see: <http://www.ag.gov.au/humanrightsframework>
228. For a description of funded projects to date, go to: <http://www.ag.gov.au/hrgrants>
229. Advocacy for Inclusion provides advocacy services to people with disabilities living in the ACT and region, to enable each individual to overcome discrimination and empower them to control their lives and participate in the community. See: <http://www.advocacyforinclusion.org>
230. Meekosha, H. & Frohmader, C. (forthcoming) OpCit.
231. Salthouse, S. (2002) 'Bridging the Digital Divide' - *A Resource Manual of Initiatives Enabling People in Disadvantaged Groups to Gain Access to the Internet*. Women With Disabilities Australia (WWDA), Tasmania.
232. Women With Disabilities Australia (WWDA) (1999) 'Final Report of the WWDA Telecommunications Survey Project'. Available online at: <http://www.wwda.org.au/wwdaprojects.htm>
233. Women With Disabilities Australia (WWDA) (2001) 'Telecommunications Use by Women with Disabilities in remote, rural and regional Australia' - Final Report. Available online at: <http://www.wwda.org.au/wwdaprojects.htm>
234. See for example: Women With Disabilities Australia (WWDA) (2008) *Submission to the Parliamentary Inquiry into pay equity and associated issues related to increasing female participation in the workforce*. Available online at: <http://www.wwda.org.au/wwdapesub1.htm>
235. Australian Government (2011) *A Guide to Australian Government Payments*. Accessed online October 2011 at: [http://www.centrelink.gov.au/internet/internet.nsf/filestores/co029\\_1109/\\$file/co029\\_1109en.pdf](http://www.centrelink.gov.au/internet/internet.nsf/filestores/co029_1109/$file/co029_1109en.pdf)
236. Commonwealth of Australia (2004) *A hand up not a hand out: Renewing the fight against poverty*. Report from the Australian Senate Community Affairs References Committee on the Poverty and Financial Hardship Inquiry. Parliament House, Canberra.
237. Price Waterhouse Coopers (2011) *Disability Expectations - Investing In A Better Life, A Stronger Australia*. Accessed online November 2011 at: <http://www.pwc.com.au/industry/government/publications/disability-in-australia.htm>
238. The mission of the Organisation for Economic Co-operation and Development (OECD) is to promote policies that will improve the economic and social well-being of people around the world. The OECD provides a forum in which governments can work together to share experiences and seek solutions to common problems. THE OECD currently has 34 member countries. See: <http://www.oecd.org>
239. International Labour Organization (2007) *The right to decent work of persons with disabilities*. Prepared for the ILO by Arthur O'Reilly. International Labour Office, Geneva.
240. Australian Bureau of Statistics (ABS) (2004) *Disability, Ageing and Carers Australia: Summary of Findings*, Cat.No. 4430.0, disaggregated data purchased from ABS by WWDA. See also: S Salthouse (2008) *From Coursework to the Workforce: Education Challenges for educators & women with disabilities*, available online at: <http://www.wwda.org.au/salthouse08wave1.htm>
241. Ibid.
242. See Women With Disabilities Australia (WWDA) (2008) *Submission to the Parliamentary Inquiry into pay equity and associated issues related to increasing female participation in the workforce*. Rosny Park, Tasmania. Available online at: <http://www.wwda.org.au/subs2006.htm>
243. Human Rights and Equal Opportunity Commission (HREOC) (2005) *National Inquiry into Employment and Disability; Issues Paper 1: Employment and Disability - The Statistics*; HREOC, Sydney.
244. The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. See: <http://www.pc.gov.au>
245. Productivity Commission (2011) *Disability Care and Support: Final Report*. Canberra. Available online at: <http://www.pc.gov.au/projects/inquiry/disability-support/report>
246. Gillard, J. (2011) *COAG delivers key step for national disability insurance scheme*. Accessed online October 2011 at: <http://www.pm.gov.au/press-office/coag-delivers-key-step-national-disability-insurance-scheme>
247. The Productivity Commission recommended in part that: The scheme should involve a common set of eligibility criteria, entitlements to individually tailored supports based on the same assessment process, certainty of funding based on need, genuine choice over how their needs were met (including choice of provider) and portability of entitlements across borders. There would be local area coordinators and disability support organisations to provide grass roots support. The insurance scheme would take a long-term view and have a strong incentive to fund cost effective early interventions, and collect data to monitor outcomes and ensure efficiency. See: 'Disability Care and Support Inquiry: Key Points' at: <http://www.pc.gov.au/projects/inquiry/disability-support/report/key-points>
248. Women With Disabilities Australia (WWDA) (2010) *Gendering the National Disability Care and Support Scheme*. WWDA Submission to Stage One of the Productivity Commission National Disability Care and Support Inquiry. Available online at: [www.wwda.org.au/WWDASubPCInquiry2010.pdf](http://www.wwda.org.au/WWDASubPCInquiry2010.pdf) or [www.wwda.org.au/WWDASubPCInquiry2010.doc](http://www.wwda.org.au/WWDASubPCInquiry2010.doc)
249. Women With Disabilities Australia (WWDA) and Women With Disabilities Victoria (WDV)(2011) *Joint Submission in Response to the Productivity Commission's Disability Care and Support Draft Report*. Available online at: <http://www.wwda.org.au/subs2011.htm>
250. See for eg: United Nations General Assembly (2000) *Resolution adopted by the General Assembly: Further actions and initiatives to implement the Beijing Declaration and Platform for Action*. Twenty-third special session, A/RES/S-23/3. See also: Preamble [q] of UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, A/RES/61/106.

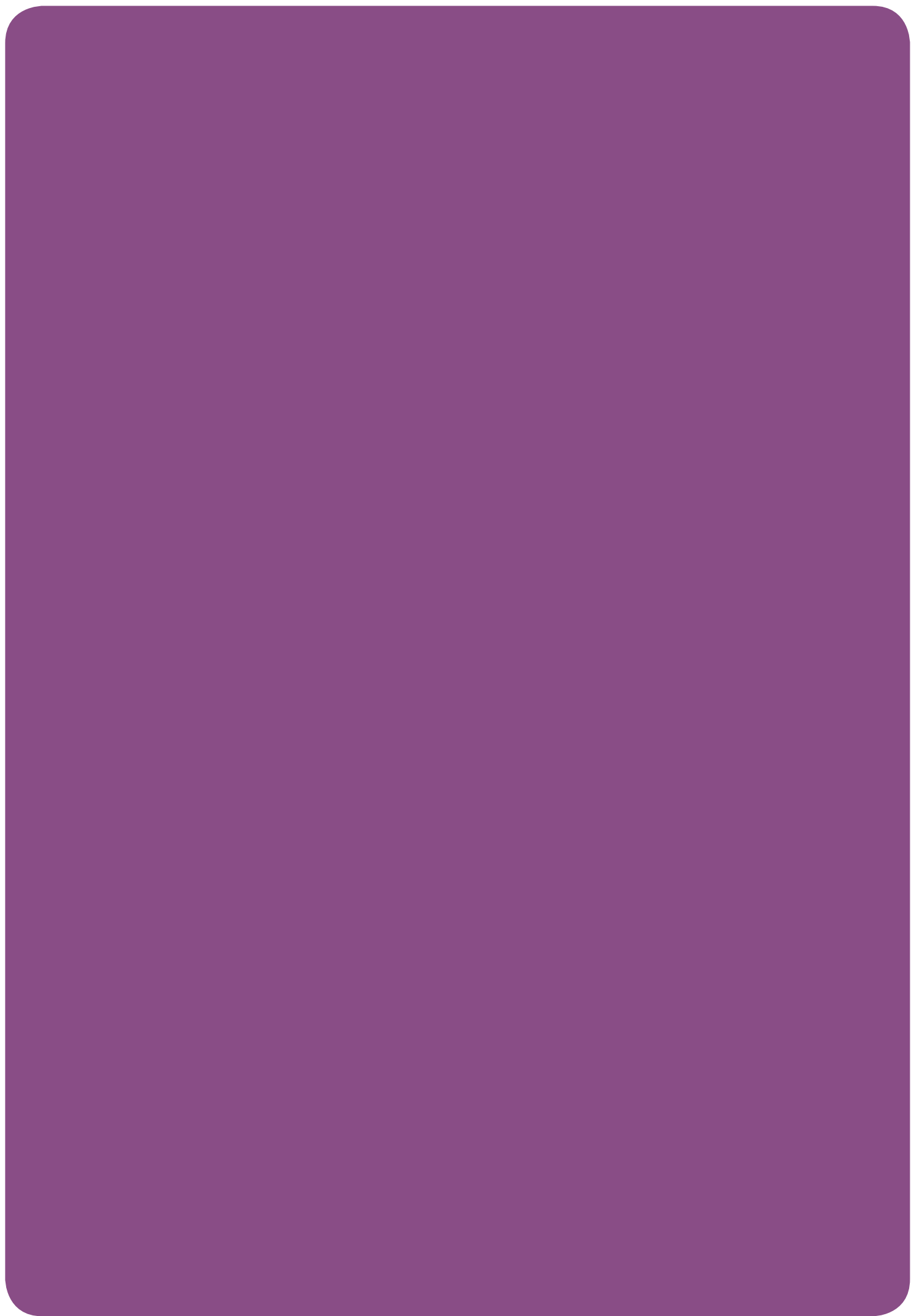
251. Women With Disabilities Victoria (2011) 'Productivity Commission ignores women with disabilities again'. Media Release, 11 August 2011; Accessed online October 2011 at: [http://www.wdv.org.au/documents/Media%20Release%20-%20Productivity%20Commission%20ignores%20women%20with%20disabilities%20again%20\(11%2008%2011\).pdf](http://www.wdv.org.au/documents/Media%20Release%20-%20Productivity%20Commission%20ignores%20women%20with%20disabilities%20again%20(11%2008%2011).pdf)
252. Meekosha, H. & Frohmader, C. (forthcoming) OpCit.
253. UN Committee on the Elimination of Discrimination against Women (CEDAW) (2010) OpCit.
254. For more information on the 'Leaders for Tomorrow' Program, go to: <http://www.leadersfortomorrow.com.au/>
255. For more information on the Indigenous Women's Program (IWP), go to: [http://www.fahcsia.gov.au/sa/indigenous/progserv/leadership/Pages/indigenous\\_womens\\_program.aspx](http://www.fahcsia.gov.au/sa/indigenous/progserv/leadership/Pages/indigenous_womens_program.aspx)
256. Women With Disabilities Australia (WWDA) (2009) OpCit.
257. The Mental Health Act 1986, the Health Services Act 1988, and the Disability Act 2006.
258. Office of the Public Advocate (Vic) 'Community Visitors'. Accessed online November 2011 at: <http://www.publicadvocate.vic.gov.au/services/107/>
259. Ombudsman NSW, *Official Community Visitor Scheme*. Accessed online November 2011 at: <http://www.ombo.nsw.gov.au/aboutus/coordnteeoffcommvstrprog.html>
260. 'Designated care facilities' are defined as being: an authorised mental health facility with in-patient services; a hostel registered as 'level three' supported accommodation; a residence with other people who also receive support from Disability Services Queensland or a paid service provider. See: <http://www.justice.qld.gov.au/justice-services/guardianship/community-visitor-program/>
261. Monfries, A. (2011) *Watchdog call: we need to keep an eye on our vulnerable*. Sunday Mail (SA) October 15, 2011. Accessed online October 2011 at: <http://www.adelaidenow.com.au/watchdog-call-we-need-to-keep-an-eye-on-our-vulnerable/story-e6frea6u-1226167473592>
262. Women With Disabilities Australia (WWDA) (1999) *Women With Disabilities and Violence - A Report of the National WWDA Violence Workshop*. Published by WWDA. Canberra.
263. Audio, e-text & Large Print PDF versions of the Booklets are included on a CD-ROM which accompanies the 'Resource Manual on Violence Against Women With Disabilities'. Braille and DAISY versions are also available on request. For more information, go to: <http://www.wwda.org.au/vrm2007.htm>
264. Healey, L., Howe, K., Humphreys, C., Jennings, C. & Julian, F. (2008) 'Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria'. Prepared for the Victorian Women with Disabilities Network Advocacy Information Service, Melbourne. The *Building the Evidence Project Report* is available in a range of formats from the website of Women With Disabilities Victoria. Go to: <http://www.wdv.org.au/violence.htm>
265. Australian Law Reform Commission (2010) Chapter 8: Family Violence and the Criminal Law - An Introduction. Mandatory reporting. In *Family Violence - A National Legal Response* (ALRC Report 114). Available online at: <http://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>
266. Australian Human Rights Commission (AHRC) *Access to Premises*. Accessed online November 2011 at: [http://www.hreoc.gov.au/disability\\_rights/buildings/access\\_to\\_premises.html](http://www.hreoc.gov.au/disability_rights/buildings/access_to_premises.html)
267. For more information on the *Access to Premises Standards*, go to: [http://www.hreoc.gov.au/disability\\_rights/buildings/access\\_to\\_premises.html](http://www.hreoc.gov.au/disability_rights/buildings/access_to_premises.html) and/or <http://www.ag.gov.au/premisesstandards>
268. United Nations Human Rights Council, Resolution 14/12: *Accelerating efforts to eliminate all forms of violence against women: ensuring due diligence in prevention*. 23 June 2010, A/HRC/RES/14/12.
269. Women With Disabilities Australia (WWDA) (2007b) OpCit.
270. Healey, L. et al (2008) OpCit.
271. Women With Disabilities Australia (WWDA) (2007b) OpCit.
272. Ibid.
273. Dowse, L., Frohmader, C. and Meekosha, H. (2010) Chapter 14: 'Intersectionality: Disabled Women'. In Easta, P. (ed) *Women and the Law in Australia*, Reed International Books Australia.
274. Healey et al (2008) OpCit.
275. Cockram, J. (2003) *Silent Voices: Women With Disabilities and Family and Domestic Violence*. A joint project of People with Disabilities (WA) Inc., the Ethnic Disability Advocacy Centre and the Centre for Social Research, Edith Cowan University, Perth, Australia.
276. Women With Disabilities Australia (WWDA) (2007b) OpCit.
277. Jennings, C. (2004) *The health impact of violence: a disability perspective*. Paper presented to the 'Home Truths' Conference, Sheraton Towers, Southgate, Melbourne, Australia.
278. Healey et al (2008) OpCit.
279. Maroondah Halfway House is located in the eastern region of Melbourne and provides emergency crisis and transitional housing and support for women and children experiencing family violence.

280. For more information on the Maroondah Halfway House work to accommodate women with disabilities escaping violence, see article 'A Safe Place for Women With Disabilities: new universal access unit at Maroondah Halfway House' in the WWDA News, Issue 2, 2010, available online at: <http://www.wwda.org.au/wwdanewsletter.htm>
281. Australian Bureau of Statistics (2011) *Recorded Crime - Victims, Australia*, 2010. Cat.No. 4510.0. Accessed online October 2011 at: <http://www.abs.gov.au/ausstats/abs@nsf/Latestproducts/4510.0Main%20Features12010?opendocument&tabname=Summary&prodno=4510.0&issue=2010&num=&view=>
282. Women With Disabilities Australia (WWDA) (2007b) OpCit.
283. Healey et al (2008) OpCit.
284. French, P., Dardel, J., & Price-Kelly, S. (2009) *Rights denied: Towards a national policy agenda about abuse, neglect and exploitation of persons with cognitive impairment*, People with Disability Australia, Sydney.
285. Women With Disabilities Australia (WWDA) (2007b) OpCit.
286. French, P. (2007) *Disabled Justice: The barriers to justice for persons with disability in Queensland*. Queensland Advocacy Incorporated (QAI), Brisbane. Accessed online October 2011 at: [http://www.qai.org.au/images/stories/docs/1987-2007/doc\\_199.pdf](http://www.qai.org.au/images/stories/docs/1987-2007/doc_199.pdf)
287. French, P. et al (2010) OpCit.
288. Women With Disabilities Australia (WWDA) (2007b) OpCit.
289. Healey et al (2008) OpCit.
290. French, P. (2007) OpCit.
291. French, P. et al (2010) OpCit.
292. Banks, A. (2011) 'Women reluctant to report abuse: top judge'. *The West Australian*, November 22, 2011. Accessed online November 2011 at: <http://au.news.yahoo.com/thewest/a/-/wa/11898578/women-reluctant-to-report-abuse-top-judge/>
293. Kemp, M. (2011) Disabled rape 'too hard to prosecute'. *The Advertiser*, June 27, 2011. Accessed online October 2011 at: <http://www.adelaidenow.com.au/ipad/disabled-rape-too-hard-to-prosecute/story-fn6bqphm-1226082413035>
294. The Health and Community Services Complaints Commissioner (HCSCC) helps people – service users, carers and service providers – resolve complaints about health and community services in South Australia, when a direct approach to the service provider is either unreasonable, or has not succeeded. See: <http://www.hcsc.sa.gov.au>
295. Ibid.
296. Australian Broadcasting Corporation (ABC) (2011) *Church denies disabled kids' sex abuse cover-up*. ABC TV 'Four Corners' September 26, 2011. Accessed online October 2011 at: <http://www.abc.net.au/news/2011-09-26/four-corners-child-abuse-claims/2942602>
297. Australian Broadcasting Corporation (ABC) (2011) *St Ann's Secret*. ABC TV 'Four Corners', October 3, 2011. Accessed online October 2011 at: <http://www.abc.net.au/4corners/stories/2011/09/22/3323669.htm>
298. Miletic, D. (2006) 'Outcry over teenage girl's assault recorded on DVD'. *The Age*, October 25, 2006. Accessed online October 2011 at: <http://www.theage.com.au/articles/2006/10/24/1161455722271.html>
299. Shtargot, S. (2007) Werribee DVD youths plead guilty, avoid jail. *The Age*, July 21, 2007. Accessed online October 2011 at: <http://www.theage.com.au/news/national/werribee-dvd-youths-plead-guilty-avoid-jail/2007/07/20/1184560043673.html>
300. Ziffer, D. (2006) YouTube yanks assault DVD. *The Age*, October 26, 2006. Accessed online October 2011 at: <http://www.theage.com.au/news/national/youtube-yanks-assault-dvd/2006/10/26/1161749222232.html>
301. Teens avoid jail over sex assault. *Brisbane Times*, November 5, 2007. Accessed online October 2011 at: <http://www.brisbanetimes.com.au/news/national/teens-avoid-jail-over-sex-assault/2007/11/05/1194117944173.html>
302. Wikipedia 'Cunt: The Movie'. Accessed online October 2011 at: [http://en.wikipedia.org/wiki/Cunt:\\_The\\_Movie](http://en.wikipedia.org/wiki/Cunt:_The_Movie)
303. Mickelborough, P. (2010) Mentally disabled women 'raped by carer' in state-run house. *Herald Sun*, October 11, 2010. Accessed online October 2011 at: <http://www.heraldsun.com.au/news/victoria/mentally-disabled-women-raped-by-carer-in-state-run-house/story-e6frf7kx-1225936849896>
304. Grace, R. (2010) Rape claims levelled against DHS worker. *The Age*, October 11, 2010. Accessed online October 2011 at: <http://www.theage.com.au/victoria/rape-claims-levelled-against-dhs-worker-20101011-16erd.html>
305. Baker, R. & McKenzie, N. (2011) Patient 'silenced' after sex abuse. *The Age*, November 21, 2011. Accessed online November 2011 at: <http://www.theage.com.au/victoria/patient-silenced-after-sex-abuse-20111120-1npeh.html>
306. French, P. et al (2010) OpCit.
307. French, P. (2007) OpCit.
308. Stewart, D. Chapter 11 Institutional culture and people with intellectual disabilities: Experiences of an inquirer. In Hauritz, M. Sampford, C. & Blencowe, S. (Eds) (1998) *Justice for People with Disabilities – Legal and Institutional Issues*. The Federation Press, Leichhardt, NSW.
309. French, P. et al (2010) OpCit.
310. Brouwer, G. (2011) *Ombudsman Investigation Assault of a Disability Services Client by Department of Human Services Staff*. Ombudsman Victoria. Accessed online October 2011 at: [http://www.ombudsman.vic.gov.au/resources/documents/Assault\\_of\\_a\\_Disability\\_Services\\_Client\\_by\\_Department\\_of\\_Human\\_Services\\_Staff.pdf](http://www.ombudsman.vic.gov.au/resources/documents/Assault_of_a_Disability_Services_Client_by_Department_of_Human_Services_Staff.pdf)
311. The Ombudsman's damning report, tabled in Parliament in March 2011, states: 'The department's response to the incident was inadequate and shows a disregard for the resident's human rights and its duty of care.'
312. Office of the Health Complaints Commissioner (Tasmania) (2005) *Report of an investigation into Ward 1E and Mental Health services in Northern Tasmania*. Report by the Health Complaints Commissioner, Tasmania.
313. NSW Ombudsman (2011) *More than board and lodging: the need for boarding house reform*. NSW Ombudsman, Sydney.
314. See: 'PWD Advocacy and Grand Western Lodge' at: <http://www.pwd.org.au/gwl.html> for a more detailed background and the current situation.
315. See also: Horin, A. (2011) Shocking abuse and neglect revealed in boarding houses across NSW. *The Sydney Morning Herald*, August 17, 2011; Accessed online October 2011 at: <http://www.smh.com.au/lifestyle/life/shocking-abuse-and-neglect-revealed-in-boarding-houses-across-nsw-20110816-1iwbk.html>
316. The Ombudsman's 2011 report states: 'My office has made many recommendations over the past nine years aimed at improving the circumstances of people living in licensed boarding houses and progressing the broader reforms. We have received repeated advice from ADHC about its intentions to progress a review of the legislation governing licensed boarding houses, and interagency work to explore options for reform of the boarding house sector. However, almost a decade in, the legislative review has not been completed, and no decisions have been made about the proposed reforms. The slow pace of work and the lack of practical action to commence necessary reforms are unreasonable given the implications for the individuals living in boarding houses. The need for concerted and sustained cross-government action to achieve real and improved outcomes for people living in licensed and unlicensed boarding houses is overdue.' See Brouwer, G. (2011) OpCit [Ombudsman's message].
317. Silmalis, L. (2011) Taskforce's house of horror fear. *The Sunday Telegraph*, October 16, 2011. Accessed online October 2011 at: <http://www.news.com.au/taskforces-house-of-horror-fear/story-e6freuzi-1226167575416>

318. Jones, G. (2009) Defenceless girl attacked while under the state's care. *The Daily Telegraph*, July 22, 2009. Accessed online October 2011 at: <http://www.dailytelegraph.com.au/news/defenceless-girl-attacked-while-under-the-states-care/story-e6freuy9-1225753486026>
319. Ibid.
320. French, P. et al (2010) OpCit.
321. Ibid.
322. French, P. (2007) OpCit.
323. Ibid.
324. Women With Disabilities Australia (WWDA) (2007b) OpCit.
325. Lowe, A. (2010) Father prostituted disabled girl. *The Age*, March 19, 2010. Accessed online October 2011 at: <http://www.theage.com.au/victoria/father-prostituted-disabled-girl-20100318-qico.html>
326. Norrie, R. (2010) Father of six pimped intellectually-disabled daughter to mates. *Herald Sun*, June 08, 2010. Accessed online October 2011 at: <http://www.heraldsun.com.au/news/victoria/father-of-six-pimped-intellectually-disabled-daughter-to-mates/story-e6frf7kx-1225876970047>
327. Fewster, S. (2011) Cadet volunteer jailed for abusing disabled girl, 12. *Adelaide Now*, September 16, 2011. Accessed online October 2011 at: <http://www.adelaidenow.com.au/news/south-australia/community-volunteer-jailed-for-abuse/story-e6frea83-1226137785170>
328. See: Australian Government Attorney-General's Department; 'Legal Aid Program'. Accessed online October 2011 at: [http://www.ag.gov.au/www/agd/ags/Page/Legalaid\\_LegalAidProgram](http://www.ag.gov.au/www/agd/ags/Page/Legalaid_LegalAidProgram)
329. See: Australian Government Attorney-General's Department; 'Community Legal Services Program'. Accessed online October 2011 at: [http://www.ag.gov.au/www/agd/ags/Page/Legalaid\\_CommunityLegalServicesProgram\\_TheCommunityLegalServicesProgram](http://www.ag.gov.au/www/agd/ags/Page/Legalaid_CommunityLegalServicesProgram_TheCommunityLegalServicesProgram)
330. See: Australian Government Attorney-General's Department; 'Indigenous Legal Assistance and Policy Reform Program'. Accessed online October 2011 at: [http://www.ag.gov.au/www/agd/ags/Page/Indigenouslawandnativetitle\\_Indigenouslawprograms\\_LegalaidforindigenousAustraliansprogram](http://www.ag.gov.au/www/agd/ags/Page/Indigenouslawandnativetitle_Indigenouslawprograms_LegalaidforindigenousAustraliansprogram)
331. See: See: Australian Government Attorney-General's Department; 'Family Violence Prevention Legal Services'. Accessed online October 2011 at: [http://www.ag.gov.au/www/agd/ags/Page/Indigenouslawandnativetitle\\_Indigenouslawprograms\\_Familyviolencepreventionlegalservices](http://www.ag.gov.au/www/agd/ags/Page/Indigenouslawandnativetitle_Indigenouslawprograms_Familyviolencepreventionlegalservices)
332. Australian Government Attorney General's Department 'Disability Discrimination Act Legal Services'. Accessed on line October 2011 at: [http://www.ag.gov.au/www/agd/ags/Page/Legalaid\\_CommunityLegalServicesProgram\\_TheCommunityLegalServicesProgram#disability](http://www.ag.gov.au/www/agd/ags/Page/Legalaid_CommunityLegalServicesProgram_TheCommunityLegalServicesProgram#disability)
333. Women With Disabilities Australia (WWDA) (2007b) OpCit.
334. Gray, A., Forell, S. & Clarke, S. (2009) *Cognitive impairment, legal need and access to justice*. Law and Justice Foundation of NSW, Justice Issues, Paper 10, March 2009.
335. Women With Disabilities Australia (WWDA) (2007b) OpCit.
336. Ibid.
337. Gray, A. et al (2009) OpCit.
338. Women With Disabilities Australia (WWDA) (2007b) OpCit.
339. Ibid.
340. French, P. (2007) OpCit.
341. Women With Disabilities Australia (WWDA) (2007b) OpCit.
342. Ibid.
343. Gray, A. et al (2009) OpCit.
344. French, P., Dardel, J., & Price-Kelly, S. (2009) *Rights denied: Towards a national policy agenda about abuse, neglect and exploitation of persons with cognitive impairment*, People with Disability Australia, Sydney.
345. Women With Disabilities Australia (WWDA) (2007b) OpCit.
346. French, P. (2007) OpCit.
347. Women With Disabilities Australia (WWDA) (2007b) OpCit.
348. Gray, A. et al (2009) OpCit.
349. French, P. (2007) OpCit.
350. Women With Disabilities Australia (WWDA) (2007b) OpCit.
351. French, P. (2007) OpCit.
352. Gudjonsson, G. cited in Bartels, L. (2011) *Police interviews with vulnerable adult suspects*. Research in Practice, Report No. 21 July 2011, Australian Institute of Criminology, Canberra.
353. Cited in Bartels, L. (2011) *Police interviews with vulnerable adult suspects*. Research in Practice, Report No. 21 July 2011, Australian Institute of Criminology, Canberra.
354. Bartels, L. (2011) *Police interviews with vulnerable adult suspects*. Research in Practice, Report No. 21 July 2011, Australian Institute of Criminology, Canberra.
355. The paper categorises 'adult vulnerability' as physical disability, mental/intellectual disability, Indigenous status and Non-English Speaking background.
356. Bartels, L. (2011) OpCit.
357. Kemp, M. (2011) Rau vows to change sex-alert system for disabled. *The Advertiser*, June 30, 2011. Accessed online October 2011 at: <http://www.adelaidenow.com.au/rau-vows-to-change-sex-alert-system/story-e6frea6u-1226085192929>



358. South Australia Evidence (Hearsay Rule Exception) Amendment Bill 2011. Accessed online November 2011 at: [http://www.legislation.sa.gov.au/LZ/B/CURRENT/EVIDENCE%20\(HEARSAY%20RULE%20EXEMPTION\)%20AMENDMENT%20BILL%202011/B\\_AS%20INTRODUCED%20IN%20HA/EVIDENCE%20EXEMPTION%20AMENDMENT%20BILL%202011.UN.PDF](http://www.legislation.sa.gov.au/LZ/B/CURRENT/EVIDENCE%20(HEARSAY%20RULE%20EXEMPTION)%20AMENDMENT%20BILL%202011/B_AS%20INTRODUCED%20IN%20HA/EVIDENCE%20EXEMPTION%20AMENDMENT%20BILL%202011.UN.PDF)
359. For a detailed and comprehensive overview and analysis of Australian legislation dealing with evidence in sexual assault proceedings, see Chapter 27 of the Australian Law Reform Commission (2010) *Family Violence - A National Legal Response (ALRC Report 114)*. Available online at: <http://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>
360. Office of the Public Advocate (Vic) '*Independent Third Persons*'. Accessed online October 2011 at: <http://www.publicadvocate.vic.gov.au/services/108/>
361. The Intellectual Disability Rights Service (IDRS) is a specialist legal advocacy service for people with intellectual disability in New South Wales. See: <http://www.idrs.org.au>
362. Queensland Advocacy Incorporated (QAI) is an independent, community-based systems and legal advocacy organisation for people with disability in Queensland, Australia. See: <http://www.qai.org.au>
363. Dowse, L., Frohmader, C. and Meekosha, H. (2010) Chapter 14: 'Intersectionality: Disabled Women'. In Easteal, P. (ed) *Women and the Law in Australia*, Reed International Books Australia.
364. WWILD works with women with intellectual and learning disabilities that have experienced or at risk of experiencing sexual violence or have become a victim of crime. WWILD runs two main programs: *The Sexual Violence Prevention Program* provides support to women with intellectual and learning disabilities aged over 15 who have experienced or are at risk of experiencing sexual violence. *The Victims of Crime Disability Training Program* provides support to people with learning and intellectual disabilities who are a victim of crime and the professionals seeking to support them. See: <http://www.wwild.org>
365. For more information on the Queensland Criminal Justice Centre (QCJC), go to: <http://www.qcjc.com.au>
366. Attorney General's Department of NSW (2008) Capacity Toolkit. Accessed online November 2011 at: [http://www.lawlink.nsw.gov.au/lawlink/diversityservices/LL\\_DiversitySrvcs.nsf/pages/diversity\\_services\\_capacity\\_toolkit](http://www.lawlink.nsw.gov.au/lawlink/diversityservices/LL_DiversitySrvcs.nsf/pages/diversity_services_capacity_toolkit)
367. Law Society of NSW (2009) *A Practical Guide for Solicitors: When a client's capacity is in doubt*. Accessed online October 2011 at: <http://www.lawsociety.com.au/idc/groups/public/documents/internetcontent/023880.pdf>
368. Women With Disabilities Australia (WWDA) (2007b) OpCit.
369. French, P. et al (2010) OpCit.
370. Women With Disabilities Australia (WWDA) (2007b) OpCit.
371. French, P. et al (2010) OpCit.
372. See also: French, P. et al (2010) for a more detailed discussion on the need for a national coordinated strategic framework.





STOP THE VIOLENCE

# BACKGROUND PAPER

NATIONAL SYMPOSIUM ON  
VIOLENCE AGAINST WOMEN  
AND GIRLS WITH DISABILITIES

SYDNEY, AUSTRALIA  
25 OCTOBER 2013



Women  
With  
Disabilities  
Australia  
(WWDA)



**WOMEN WITH DISABILITIES  
AUSTRALIA (WWDA)**

PO BOX 605 ROSNY PARK  
TASMANIA 7018 AUSTRALIA

**T** +61 (3) 6244 8288

**F** +61 (3) 6244 8255

**E** [wwda@wwda.org.au](mailto:wwda@wwda.org.au)



**PEOPLE WITH DISABILITY  
AUSTRALIA (PWD)**

52 PITT ST REDFERN  
NSW 2016 AUSTRALIA

**T** +61 (2) 9370 3100

**F** +61 (2) 9318 1372

**E** [stvp@pwd.org.au](mailto:stvp@pwd.org.au)



**THE UNIVERSITY OF  
NEW SOUTH WALES (UNSW)**

SYDNEY  
NSW 2052 AUSTRALIA

**T** +61 (2) 9385 2608

**F** +61 (2) 9385 1040

**E** [stvp@unsw.edu.au](mailto:stvp@unsw.edu.au)

# CONTENTS

ACKNOWLEDGEMENTS	7
EXECUTIVE SUMMARY	8
1 PROJECT OVERVIEW	10
1.1 Project Context	11
1.2 Project Objectives	13
1.3 Project Focus and Scope	15
1.4 Project Governance and Implementation	16
2 BACKGROUND TO THE ISSUE	17
2.1 Context	17
2.2 Understanding Disability	18
2.3 Understanding Violence against Women	21
2.4 Understanding Violence against Women and Girls with Disabilities	25
3 INFORMATION GATHERING PROCESSES AND OUTCOMES	33
3.1 Desk-Based Research and Analysis of Legislation and Polices	34
3.2 Stakeholder Engagement and Consultations	34
3.3 National Survey	37
4 KEY EMERGING ISSUES	45
THEME 1 RECOGNISING VIOLENCE	46
1.1 Context	46
1.2 Evidence	47
1.3 Summary Implications	55
THEME 2 RESPONDING TO VIOLENCE	57
2.1 Context	57
2.2 Evidence	57
2.3 Summary Implications	66
THEME 3 INCLUSION AND PARTICIPATION	68
3.1 Context	68
3.2 Evidence	68
3.3 Summary Implications	74
THEME 4 SECTOR DEVELOPMENT	75
4.1 Context	75
4.2 Evidence	75
4.3 Summary Implications	77
THEME 5 CROSS-SECTOR COLLABORATION	79
5.1 Context	79
5.2 Evidence	79
5.3 Summary Implications	86
THEME 6 DATA CAPTURE AND USE	87
6.1 Context	87
6.2 Evidence	87
6.3 Implications	93
REFERENCES	94

## LIST OF FIGURES

Figure 1	Stakeholder group representation	38
Figure 2	Size of service provider respondents	40
Figure 3	Number of WGWD having accessed human services in the past year	47
Figure 4	Percentage of women service users with disabilities recorded by service providers as having experienced violence in the past year	48
Figure 5	Types of violence recorded by service providers	50
Figure 6	Types of Violence Recorded by Service Providers	51
Figure 7	Involvement in awareness campaigns and programs	53
Figure 8	Issues facing WGWD experiencing/at risk of violence	54
Figure 9	Organisation meets current demand	58
Figure 10	Staff require more training to meet demand	58
Figure 11	Organisation reallocates resources to meet demand	58
Figure 12	Organisation targets services more tightly or limit service levels to meet demand	58
Figure 13	Organisation is unaware of current level of demand	58
Figure 14	Waiting lists are growing for WGWD experiencing/at risk of violence	58
Figure 15	Service capacity is constrained by eligibility criteria	58
Figure 16	Service capacity is constrained by the level of available resources	58
Figure 17	Awareness of demand across sectors	59
Figure 18	Recognition of violence against women and girls with disabilities in organisational policies, protocols and procedures	60
Figure 19	Proportion of service providers with a procedure in place for women violence is suspected in the absence of formal disclosure	61
Figure 20	Priority measures for service capacity improvement	64
Figure 21	Participation of WGWD in service development and planning	69
Figure 22	Mechanisms used to promote the participation and inclusion of women with disabilities in service development and planning	70
Figure 23	Mechanisms used to obtain service user feedback from WGWD	70
Figure 24	Service evaluation targeted to the needs of WGWD	71
Figure 25	Facilities and services provided to ensure accessibility	72
Figure 26	Facilities and services offered by violence and disability services	72
Figure 27	Measures for participation of WGWD in activity planning and development	73



Figure 28	Violence and disability awareness training completed in the past five years	76
Figure 29	Reasons for any lack of staff training	76
Figure 30	Cross-agency collaboration on violence against women with disabilities	79
Figure 31	Inter-sector collaboration on violence against women with disabilities	80
Figure 32	Level of inter-agency collaboration on violence against women and girls with disabilities	81
Figure 33	Level of inter-sector collaboration on violence against women and girls with disabilities	81
Figure 34	Cross-agency collaboration on violence against women and girls with disabilities	82
Figure 35	Cross-sector collaboration with representative groups, peak bodies and advocacy agencies on violence against women and girls with disabilities	83
Figure 36	Level of cross-agency collaboration on issues of violence against women with disabilities	83
Figure 37	Level of cross-sector collaboration with representative groups, peak bodies and advocacy agencies on issues of violence against women with disabilities	84
Figure 38	Inter-sector collaboration on violence against women and girls with disabilities	85
Figure 39	Data collected by service providers	87
Figure 40	Data reporting patterns	88
Figure 41	Data on service users collected by policy development agencies	89
Figure 42	Patterns of disaggregation of data on people with disabilities	90
Figure 43	Patterns of disaggregation of data on women experiencing or at risk of violence	90
Figure 44	Data reported by representative organisations	92
Figure 45	Information captured by representative organisations about women and girls with disabilities experiencing or at risk of violence	92

## LIST OF TABLES

Table 1	Respondent jurisdiction and locational category	38
Table 2	Service providers across service sectors	39
Table 3	Areas of service provision	41
Table 4	Sectoral Spread of Policy Development Agencies	42
Table 5	Representative organisation target group	43
Table 6	Activities undertaken by Representative Organisations	44

## ABBREVIATIONS

<b>ABS</b>	<u>Australian Bureau of Statistics</u>
<b>ACOSS</b>	<u>Australian Council of Social Services</u>
<b>AHRC</b>	<u>Australian Human Rights Commission</u>
<b>ALRC</b>	<u>Australian Law Reform Commission</u>
<b>AWAVA</b>	<u>Australian Women Against Violence Alliance</u>
<b>CALC</b>	<u>Community Affairs Legislation Committee</u>
<b>CALD</b>	<u>Culturally and Linguistically Diverse</u>
<b>CDA</b>	<u>Children with Disability Australia</u>
<b>CEDAW</b>	<u>Committee on the Elimination of Discrimination Against Women</u>
<b>CESCR</b>	<u>Committee on Economic, Social and Cultural Rights</u>
<b>COAG</b>	<u>Council of Australian Governments</u>
<b>CROWD</b>	<u>Center for Research on Women with Disabilities</u>
<b>CRPD</b>	<u>Convention on the Rights of Persons with Disabilities</u>
<b>CSW</b>	<u>Committee on the Status of Women</u>
<b>DDA</b>	<u>Disability Discrimination Act</u>
<b>DRALHRO</b>	<u>Disability Representative, Advocacy, Legal and Human Rights Organisations</u>
<b>DS</b>	<u>Disability Services</u>
<b>DSA</b>	<u>Disability Services Act</u>
<b>ECG</b>	<u>Expert Consultative Group</u>
<b>FaHCSIA</b>	<u>Department of Families, Housing, Community Services and Indigenous Affairs</u>
<b>HACC</b>	<u>Home and Community Centre</u>
<b>HRC</b>	<u>UN Human Rights Council</u>
<b>INWWD</b>	<u>International Network of Women with Disabilities</u>
<b>LGBTQI</b>	<u>Lesbian, Gay, Bisexual, Transgendered, Queer and Inter-sex</u>
<b>MDS</b>	<u>Minimum Data Set</u>
<b>NDIS</b>	<u>National Disability Insurance Scheme</u>
<b>NDISRG</b>	<u>National Disability Insurance Scheme Reference Group</u>
<b>NDS</b>	<u>National Disability Strategy</u>
<b>NGO</b>	<u>Non-Government Organisation</u>
<b>NPIP</b>	<u>National Plan Implementation Plan</u>
<b>OHCHR</b>	<u>Office of the High Commissioner for Human Rights</u>
<b>PIC</b>	<u>Project Implementation Committee</u>
<b>PSG</b>	<u>Project Steering Group</u>
<b>PWDA</b>	<u>People with Disability Australia</u>
<b>SDAC</b>	<u>Survey of Disability, Ageing and Carers</u>
<b>STVP</b>	<u>Stop the Violence Project</u>
<b>UNFPA</b>	<u>United Nations Population Fund</u>
<b>UNGA</b>	<u>United Nations General Assembly</u>
<b>UNSW</b>	<u>University of New South Wales</u>
<b>WWDA</b>	<u>Women With Disabilities Australia</u>





## ACKNOWLEDGEMENTS

This Background Paper has been prepared by the Stop the Violence Project (STVP) research team at the University of New South Wales:

- Dr Leanne Dowse
- Dr Karen Soldatic
- Dr Aminath Didi
- Ms Georgia van Toorn

In conjunction with Ms Carolyn Frohmader, Women With Disabilities Australia.

For additional material drawn on in the development of the report, the authors acknowledge and thank:

- Ms Fiona Given
- Ms Karen Jordan

For assistance with survey design, analysis and interpretation the authors acknowledge and thank Dr Shaun Wilson, Macquarie University.

Material regarding stakeholder engagement and consultations is provided by the Stop the Violence Project team at People with Disability Australia:

- Ms Therese Sands
- Ms Wendi Wicks
- Mr Peter Darby

The authors would like to acknowledge and thank Ms Elizabeth Broderick, Sex Discrimination Commissioner at the Australian Human Rights Commission, for her role in leading and guiding the steering group for the project. Acknowledgement and thanks also go to the members of the Project Steering Group (PSG) and the Expert Consultative Group (ECG) for their valuable contributions in guiding the outputs of the project.

For her vision, foundational work and project leadership the authors acknowledge and thank Ms Carolyn Frohmader, Executive Director, Women with Disabilities Australia.

This Background Paper is a contracted deliverable to the Australian Government Department of Social Services who have provided funding under the National Plan to Reduce Violence Against Women and their Children 2010-2022 to the project, Stop the Violence: Improving Service Delivery for Women and Girls with Disabilities.

### SUGGESTED CITATION

Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper. Hobart: Women with Disabilities Australia.



## EXECUTIVE SUMMARY

Women With Disabilities Australia (WWDA) is the peak non-government organisation (NGO) for women with all types of disabilities in Australia. WWDA is run by women with disabilities, for women with disabilities, and represents more than 2 million disabled women in Australia. WWDA's work is grounded in a rights-based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. Promoting the rights of women and girls with disabilities to freedom from violence, exploitation and abuse and to freedom from torture or cruel, inhuman or degrading treatment are key policy priorities of WWDA.

The Stop the Violence Project (STVP) emerges from WWDA's long standing commitment to addressing one of the most pressing issues for its membership: violence against women and girls with disabilities in Australia. Overseen by WWDA and conducted by a research team at the University of New South Wales (UNSW) in conjunction with a project team from People with Disabilities Australia (PWDA), the project is national in scope and is intended to lay the groundwork for improved service provision by building the evidence-base for future reforms so that the service system is more responsive to the needs of women and girls with disabilities. The immediate objective of the project is to investigate and promote ways to support better practice and evidence-based service system improvements to prevent violence and, improve access to, and responses of, governments and services for women and girls with disabilities experiencing, or at risk of violence.

This *Background Paper* presents outcomes of an evidence-building project, providing in-depth material to support the *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia*. A further project document *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia: Discussion Paper* which summarises the evidence emerging and

identifies principles and strategies to enhance good policy and practice has been prepared to inform deliberations at the National Symposium on Violence against Women and Girls with Disabilities conducted in Sydney in October 2013.

The National Symposium on Violence against Women and Girls with Disabilities aims to:

- Raise awareness of the issue of violence against women and girls with disabilities and foster an understanding of the issue within a human rights framework;
- Engage high-level stakeholders and decision-makers in moving forward to address violence against women and girls with disabilities;
- Foster collaborative approaches to policy development and service provision by strengthening cross-sector relationships and leadership for sustaining change in the identification and implementation of better practice models to prevent violence against women and girls with disabilities;
- Identify measures for the longer-term sustainability of addressing violence against women and girls with disabilities.

The proceedings and outcomes of the National Symposium will be collected and made available in a further document: *Report of the Proceedings and Outcomes of the National Symposium on Violence against Women and Girls with Disabilities*.

This background paper provides information on the project context, activities and outcomes, highlighting six key issues and their implications that are considered a priority in addressing reform in the area of violence against women and girls with disabilities. The paper is structured according to the following framework:

**SECTION 1 PROJECT OVERVIEW** sets out the relevant environment and context for the project in terms of its links with the *National Plan to Reduce Violence against Women and their Children 2010-2022* and gives an overview of its structure and aims.

**SECTION 2 BACKGROUND TO THE ISSUE** considers the international and national literature on violence against women and girls with disabilities by exploring current understandings of disability, of violence against women, and of the issues that emerge when these two intersect. The section identifies *definitions* of these experiences, develops a *human rights* perspective in relation to them, explores their *nature and prevalence*, and gives an overview of the relevant current *legislative and policy* environment.

**SECTION 3 INFORMATION GATHERING PROCESSES AND OUTCOMES** details the overall strategy utilised to gather the evidence-base for the project. This section includes a description of the processes utilised in the desk-based research and analysis of legislation and policies; approaches to stakeholder identification, engagement and to consultation with women with disabilities; and a national survey of human service and justice sector service providers, policy makers and representative organisations. Summary results emerging from these activities are presented.

**SECTION 4 KEY EMERGING ISSUES - CONTEXT, EVIDENCE AND IMPLICATIONS** sets out the six key issues emerging from survey findings, consultations with women with disabilities, research literature reviews and legislative and policy mapping.

This section brings into focus current challenges in addressing issues of violence for women and girls with disabilities experiencing or at risk of experiencing violence. It identifies the implications of these issues for reform to enable adequate, appropriate, and responsive support for this group. The six key themes are:

- THEME 1** RECOGNISING VIOLENCE
- THEME 2** RESPONDING TO VIOLENCE
- THEME 3** INCLUSION AND PARTICIPATION
- THEME 4** SECTOR DEVELOPMENT
- THEME 5** CROSS-SECTOR COLLABORATION
- THEME 6** DATA CAPTURE AND USE

A close-up photograph of a woman's shoulder and upper arm. She has a tattoo that reads 'WWDA' (Women With Disabilities Australia) in a stylized font. She is wearing a small, dark, round earring. The background is dark and out of focus.

# 1 PROJECT OVERVIEW

## SUMMARY POINTS

- One in three women experience physical violence and almost one in five women experience sexual violence. Of the women experiencing physical violence, 85 per cent are assaulted by a current or former partner, family, friend or other known male. Three-quarters of physical attacks occur in the woman's home. Women with disabilities make up 20 per cent of the population of women. It is believed that over a third of women and girls with disabilities
- Recognising that all forms of violence against women are unacceptable, the Commonwealth Government developed a national strategy of zero tolerance to violence against women, resulting in the twelve-year *National Plan to Reduce Violence Against Women and their Children 2010-2022* (The National Plan).
- Through four three-year Action Plans, the National Plan aims to drive necessary change to achieve significant and sustained reduction in violence against women. This will be done by making communities safe and free from violence, building respectful relationships, strengthening Indigenous communities, meeting the needs of women and children experiencing violence, providing effective justice responses, and by holding the perpetrators to account. Multiple projects have been funded by the Commonwealth Government to support this process in a range of priority areas.
- The Stop the Violence Project is one such project, implemented by Women With Disabilities Australia (WWDA). The STVP is a national project which aligns with the CRPD and the *National Disability Strategy 2010-2020*. The STVP seeks to identify structural issues to improve service responses to women and girls with disabilities experiencing or at risk of domestic and family violence.
- The long-term objective of the STVP is to contribute towards improving the overall quality of life for women and girls with disabilities in Australia in order to promote and protect their rights to freedom from violence, exploitation and abuse (Article 16, CRPD). The immediate objective of the project is to investigate and promote ways to support better practice and evidence-based service system improvements to prevent violence and, improve access to, and responses of, governments and services for women and girls with disabilities experiencing, or at risk of violence.
- Funded by the Department of Social Services, WWDA is implementing the project with support from UNSW and PWDA. The project encompasses high-level policy input through its project steering group (PSG) and a range of expert advice from its expert consultative group (ECG) members.



## 1.1 PROJECT CONTEXT

One in three women in Australia has experienced physical violence and almost one in five has experienced sexual violence (ABS 2006). Of those women experiencing physical assault, 85 per cent are assaulted by a current or former partner, family, friend or other known male; and three-quarters of these attacks occurred in the woman's home (ABS 2006). Recognising that all forms of violence against women is unacceptable, the Australian Government developed a national strategy of zero tolerance to violence against women, resulting in the twelve-year *National Plan to Reduce Violence Against Women and their Children 2010-2022*.

The National Plan, for the first time, brings together the efforts of all Australian Governments to reduce violence against women and their children. It provides a strategic agenda for leveraging and influencing related policies to ensure that responses take account of the needs of the victims and that programs implemented are effectively and appropriately targeted to both prevent and redress the issue (CEDAW 2012). The National Plan targets two main types of violence: domestic and family violence, and sexual assault (Commonwealth of Australia 2010). Over its twelve year period, it aims to achieve the following six outcomes:

- communities are safe and free from violence;
- relationships are respectful;
- Indigenous communities are strengthened;
- services meet the needs of women and children experiencing violence;
- justice responses are effective; and
- perpetrators stop their violence and are held to account.

The above outcomes are to be delivered through four three-year Action Plans, each underpinned by a key theme to drive necessary

change needed to achieve a significant and sustained reduction in violence against women (CEDAW 2012). The four three-year Action Plans and the themes they highlight are as follows:

- The first Action Plan (2010-2013) *Strong Foundation* focuses on building a strong foundation for the National Plan. It identifies key strategies and actions as well as the national initiatives to create a foundation for future work to be undertaken during the life of the National Plan. It outlines how the Commonwealth Government, along with all State and Territory Governments and the community, will work together to lay the groundwork for the future.
- The second Action Plan (2013-2016) *Moving Ahead* will take stock of what has worked well in the first three years and consolidate the evidence-base for the effectiveness of the strategies and actions implemented.
- The third Action Plan (2016-2019) *Promising Results* will deliver solid and continuing progress in best practices and policies.
- The fourth Action Plan (2019-2022) *Turning the Corner* is expected to see the delivery of tangible results in terms of reduced prevalence of domestic violence and sexual assault, reduced proportions of children witnessing violence, and an increased proportion of women who feel safe in their communities (CEDAW 2012: 4-5).

Under the National Plan, each State and Territory is expected to develop its own jurisdictional implementation plan outlining the actions being undertaken locally. These implementation plans are expected to reflect good practice reforms already underway in each jurisdiction or new initiatives being undertaken. It is expected that some States and Territories will use their existing family violence strategies and implementation frameworks to implement the National Plan.

The Commonwealth and State and Territory Governments have committed to implement better understanding and improving the quality of services and responses to women and their children who are experiencing, or at risk of domestic and family violence (CEDAW 2012: 12). Multiple projects have been funded to support this process in a range of priority areas. Although the approach for individual projects may differ, the common aim is to help build knowledge and understanding of what can work in key service delivery areas and to promote the adoption of good practice models or approaches (CEDAW 2012: 12).

A National Centre of Excellence bringing together all existing and new research under an agreed national agenda, and a National Foundation to Prevent Violence against Women and their Children to drive cultural and attitudinal change have been created under the National Plan (AHRC 2012a: 8, FaHCSIA 2013). The Plan's implementation and monitoring is overseen by a tripartite National Plan Implementation Panel (NPIP) consisting of Commonwealth and all State and Territory Governments and non-government representatives from domestic violence and sexual assault sectors, peak bodies, academia, justice and specific population groups such as Indigenous women, culturally and linguistically diverse women and women with disabilities (AHRC 2012a, CEDAW 2012).

The Stop the Violence Project is one such Commonwealth Government project which seeks to improve service responses to women and girls with disabilities experiencing or at risk of domestic and family violence (CEDAW 2012). The STVP, implemented by the Australian non-government organisation, Women With Disabilities Australia (WWDA), seeks to identify structural issues which may impact upon women and girls with disabilities who have experienced violence, in accessing services as well as addressing the capacity of services to respond effectively (CEDAW 2012: 12).

The STVP addresses two key immediate national initiatives specifically focussed on women and girls with disabilities. These include:

- support for better service delivery for women and girls with disabilities through the development of new evidence-based approaches where existing policy and service responses have proved to be inadequate; and
- investigation and promotion of ways to improve access and responses to services for women and girls with disabilities.

The STVP also aligns with the Convention on the Rights of Persons with Disabilities (CRPD) and the *National Disability Strategy 2010-2020*, in its future action '2.3: Develop strategies to reduce violence, abuse and neglect of people with disability'. A key action to achieve this is through the implementation of the National Plan. The *National Disability Strategy 2010-2020* will be delivered in three phases through the following implementation plans:

- The first implementation plan (2011-2014) *Laying the Groundwork* sets the foundation for each State and Territory Government to have its own disability plan to improve outcomes through mainstream policies, programs, services and infrastructure.
- The second implementation plan (2015-2018) *Driving Action* will, in consultation with people with disabilities and their representative organisations, outline new priority actions as well as ongoing commitments to consolidate actions that are driving improved outcomes and identify where more effort is needed.
- The third implementation plan (2019-2022) *Measuring Progress* will identify new and emerging outcomes to be implemented in order to ensure the objectives of the *National Disability Strategy 2010-2020* are met.



Each implementation plan will be underscored by the need for a change in attitudes towards disability by governments and the broader community that promotes dignity and human rights of people with disabilities, and supports participation in all aspects of community life. This is required to achieve lasting social change and to improve outcomes for people with disabilities beyond the life of the *National Disability Strategy 2010-2020* (NDSIRG 2012).

## 1.2 PROJECT OBJECTIVES

The long-term objective of the STVP is to contribute towards improving the overall quality of life for women and girls with disabilities in Australia in order to promote and protect their rights to freedom from violence, exploitation and abuse (Article 16 of the CRPD). The project is national in scope and is intended to lay the groundwork for improved service provision by building the evidence-base for future reforms so that the service system is more responsive to the needs of women and girls with disabilities (WWDA 2011).

The immediate objective of the project is to investigate and promote ways to support better practice and evidence-based service system improvements to prevent violence and, improve access to, and responses of, governments and services for women and girls with disabilities experiencing, or at risk of violence. System improvements include improving education and awareness about sexual, physical and verbal assault and, domestic and family violence for women and girls with disabilities.

The STVP addresses these objectives through:

- 1** Building the evidence-base by mapping and analysing good policy and practice models to prevent violence and improve access to, and responses of, services for women and girls with disabilities experiencing or at risk of violence through:
  - engaging and consulting with key stakeholders including representatives from governments and the domestic violence, sexual assault, disability, advocacy and homelessness sectors; and culturally and linguistically diverse and regional, rural and remote communities;
  - acknowledging and building on the existing evidence-base with regard to existing standards and requirements;

- examining the role of domestic violence/sexual assault and disability service providers (including online support services) in the context of cross-sector integrated service delivery;
  - analysing key gaps and service delivery barriers, fragmented service delivery or unnecessary duplication of programs and/or services;
  - improving understanding of the type, range and effectiveness of service system responses; and
  - identifying key areas where services could adopt new or promising practices.
- 2** Conducting and reporting on the proceedings and outcomes of a National Symposium which aims to:
- raise awareness of the issue of violence against women and girls with disabilities and to foster an understanding of the issues within a human rights framework;
  - engage high-level stakeholders and decision-makers in moving forward to address violence against women with disabilities;
  - foster collaborative approaches to policy development and service provision; and
  - identify measures for the longer term sustainability of addressing violence against women and girls with disabilities.
- 3** Developing a good policy and practice compendium to address violence against women and girls with disabilities including:
- practical information and resources to improve access to, and responses of, service systems with a particular focus on domestic violence/sexual assault and disability services for women and girls with disabilities experiencing or at risk of violence including general principles for application;
  - recommendation of models, responses and approaches to support engagement, participation, representation, information sharing and decision-making of women and girls with disabilities; and
  - identification and advice on structural and systemic issues (including though not limited to legislation, regulatory frameworks, policy and programs, data and monitoring).

### 1.3 PROJECT FOCUS AND SCOPE

The STVP focuses on reforming service provision for women and girls with disabilities who are experiencing or at risk of violence. It is recognised that although this project may be unable to address the myriad issues and complexities inherent in the multiple forms of violence perpetrated against women and girls with disabilities, it investigates and identifies gaps and good practice models for improvement of services. Through stakeholder engagement, consultations and survey, the project lays the groundwork for improved service provision by building an evidence-base for future reforms so that the service system is more responsive to the needs of women and girls with disabilities who are affected by violence. It includes particular emphasis on disability, women's, domestic and family violence, and sexual assault services, but where possible explores issues for other welfare services including for example housing, and issues relevant for justice sector services including for example legal services and law enforcement.

Although the project's predominant focus is on issues for women with disabilities who are or are at risk of experiencing violence, it does seek to include recognition of the circumstances of young women entering relationships or whose domestic circumstances are changing from the family home to other environments/ independence and the violence they may experience. The term 'women and girls with disabilities' utilised is consistent with this focus. It is recognised however that the unique experience of girls with disabilities requires different considerations in research, practice and response which are beyond the scope of the current project.

### BOX 1 DEFINITION OF VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES

#### FOR THE PURPOSES OF THIS PROJECT

- The term 'violence against women' means: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations Declaration on the Elimination of Violence against Women, 1993).
- The term 'family violence' is used in accordance with the Australian Law Reform Commission's suggestions on types of family violence experienced by people with disabilities, including domestic sexual or physical assault; stealing and financial exploitation including misappropriation of social security payments and other benefits and concessions; neglect and deprivation of things such as shelter, nutrition and essential medical treatment; specific types of abuse related to their disability such as withholding equipment, food and medication; and forced sterilisation and abortion (ALRC 2012).

A definition of 'violence' in line with the National Plan is utilised and usage of the term 'family violence' reflects the definition recommended by the 2012 Australian Law Reform Commission Report, *Family Violence and Commonwealth Laws – People with Disability*. These are captured in Box 1: Definition of Violence against Women and Girls with Disabilities.

## 1.4 PROJECT GOVERNANCE AND IMPLEMENTATION

The STVP is funded by the Department of Social Services and is overseen by WWDA who sub-contracted UNSW to undertake the research to provide the evidence-base of current policy and practice and PWDA to facilitate stakeholder engagement and consultations; public information management on the project; organise and hold the National Symposium; and prepare and finalise the *Good Policy and Practice Compendium* based on the evidence and information gathered throughout the evidence mapping process of the project. The Project Implementation Committee (PIC) led by WWDA, and comprised of staff from UNSW and PWDA, monitors implementation of the STVP to ensure that the project outputs are delivered in a timely and effective manner and remain in line with the contracted requirements.

The project is designed to ensure that the goals, objectives and outputs are met in line with the contracted deliverables and timeframes. Based on the understanding that the success of the STVP is dependent on cooperation between all levels of government and across different sectors, the project is structured so that there is continuous consultation and engagement with key stakeholders from all jurisdictions and relevant sectors. Advice on implementation is

provided by a Project Steering Group (PSG) consisting of high-level officials from each State and Territory Government agency with responsibility in the area, as well as key experts representing the non-government women's and disability sectors including National Disability Services (NDS), the Australian Council of Social Services (ACOSS), the Australian Women Against Violence Alliance (AWAVA) and Children with Disability Australia (CDA). The PSG is chaired by the Sex Discrimination Commissioner of the Australian Human Rights Commission, Ms Elizabeth Broderick. PSG meetings are held quarterly throughout the life of the project. The project is scheduled for completion at the end of December 2013.

The STVP also seeks individual expertise and advice from an Expert Consultative Group (ECG), consisting of a targeted group of experts in issues relating to violence prevention and responses for women and girls with disabilities. They provide voluntary expert advice and feedback on key outputs based on their knowledge of and expertise in the field. The group does not meet, but rather provides advice in electronic form.



## 2 BACKGROUND TO THE ISSUE

- Global studies suggest that women and girls with disabilities experience violence more intensely and frequently than either their male counterparts or women and girls without disabilities. It is believed that they are twice as likely to experience violence, their experiences last over a longer period of time, and more severe injuries result from the violence. In Australia, although there is anecdotal evidence to support this, there has been very little published research on the issue.
- The current situation in Australia is characterised by inadequate recognition and response to the needs of those women and girls with disabilities who have experienced or are at risk of experiencing violence. There is limited data and research available on the prevalence and nature of violence against women and girls with disabilities. Similarly little is known about the capacity of services to recognise and respond appropriately and effectively when such violence occurs.
- Approximately 20 per cent of the Australian population report a disability, with no significant differences in the prevalence of disabilities between males and females. Disability impacts Indigenous Australians more than non-Indigenous people.
- Negative stereotypes of disability have contributed to the marginalisation and discrimination of women and girls with disabilities, excluding their participation as full and equal citizens in the society.
- Understanding violence against women has been challenging in the Australian context as it was generally considered a 'hidden' problem confined to the private sphere, creating 'invisibility' around the issue.
- The entry into force of international human rights treaties such as CEDAW, CRC and CRPD marked the beginning of a new era in promoting respect for the inherent dignity of women and girls with disabilities and their full and equal participation in society.
- No uniform definition of violence against women exists across jurisdictions in Australia. For the definition utilised in this project see Box 1: Definition of Violence against Women and Girls with Disabilities.

### 2.1 CONTEXT

It is recognised that the nature of the experience of violence is intensified in frequency, extent and nature when gender and disability intersect. In Australia, women and girls with disabilities experience higher levels of violence compared to women and girls without disabilities, and they are more likely to experience violence in residential and institutional settings (AHRC 2012a). Violence against women and girls with disabilities has been identified as more extensive than violence amongst the general population and is also more diverse in nature than for women in general (Healey et al 2013). Research suggests that women and girls with disabilities are more likely to experience domestic violence and sexual assault than women without disabilities and are subjected to violence and abuse by a greater number of perpetrators than women without disabilities (WWDA 2007, CROWD 2009).

In common with women and girls who experience violence and abuse, women and girls with disabilities are likely to know the perpetrators of this violence, as a partner or family member (CROWD 2009). The presence of disability however means that women and girls with disabilities face a higher risk of

violence and abuse by others who are in their lives due to their support needs, such as health care providers or caregivers. Those who live in residential and institutional settings including for example disability, aged care and correctional settings are more likely to experience violence. The nature of this violence and abuse can include for instance withholding medicine and assistive devices, such as wheelchairs, or refusal to assist with daily needs like bathing, dressing, or eating (Women's Health 2011). Moreover, experiences of violence are compounded by the fact that many women with disabilities experience difficulties in obtaining help in situations of violence. For example, most women's crisis shelters are not accessible to women with disabilities and therefore, in many instances, women with disabilities are unable to leave violent environments (Healey et al 2008). Similarly, women with intellectual disabilities experience higher rates of sexual violence and abuse (Carlson 1997), financial exploitation, physical assault, and emotional abuse and have fewer, or are unaware of, pathways to safety and redress (Hague et al 2011).

Global studies suggest that, irrespective of their country, women and girls with disabilities are marginalised, neglected, violated, excluded and isolated at higher rates than their non-disabled counterparts (UNFPA 2005). Their silence is echoed in the lack of recognition of their specific risks and needs by legislators, policy makers and service providers. This is largely the case in contemporary Australia where there is an urgent need to make this issue of violence against women and girls with disabilities visible to policy makers and practitioners (Healey et al 2013). A particular challenge here is to understand the complex issues which emerge for women, for service systems and for policy makers and legislators when disability, gender and violence intersect. The following sections consider the areas of disability and violence against women then provide a synthesis of the challenges in bringing together these two separate spheres.

## 2.2 UNDERSTANDING DISABILITY

The ways in which disability is understood has implications for responses to women and girls with disabilities at risk of, or experiencing, violence. In recent decades focus has moved beyond simply considering an individual's body, intellect or behaviour to examine disability in the content of more complex set of social, political, material and cultural relationships (Meekosha & Dowse 2007) and to recognise the human rights of people with a disability.

### 2.2.1 DEFINITIONS OF DISABILITY

Traditionally, a focus on individual incapacity or the 'tragedy' of disability saw people with disabilities as dependent and in need of care and protection (Oliver 1983, Finkelstein 1993), resulting in their exclusion from participation in the wider community. Similarly, traditions of medicalising disability (Oliver 1990) placed emphasis on intervention by medical, rehabilitation, psychology and educational professionals whose aim is to diagnose, treat or cure a person's impairments, separate from their social context. Since the 1980s, understanding of the ways in which society is organised and structured to create and sustain disability has emerged. This suggests that it is not the individual characteristics that constrain full participation in society, but a range of barriers within society - such as misconceptions, discrimination, inaccessible environments/buildings, communications and information and lack of appropriate supports that prevent full participation by people with disabilities in all aspects of community life (Corker & Shakespeare 2002, Stein & Stein 2007).

Most recently, considerations have widened to encompass the idea that the disability experience is uniquely shaped by cultural conditions, social circumstances and personal experiences of different impairments. Importantly a feminist analysis of disability has



argued that simplistic bio-medical and social interpretations are particularly inadequate to understand the position of women with disabilities (Thomas 2004, Frohmader & Meekosha 2012). Informed by this work, the experience of disability is understood to be shaped by a complex range of intersecting factors including gender, race, ethnicity, geographic/geopolitical location, sexuality and socio-economic positioning. This brings into focus a fuller range of social, political, cultural, economic and individual aspects which intersect in complex and diverse ways to marginalise people with disabilities (Meekosha & Shuttleworth 2009).

This focus on marginalisation and discrimination is underpinned by an understanding of people with disabilities as the bearers of human rights. The human rights-based approach identifies people with disabilities as subjects of human rights law on an equal basis, recognises that disability is an issue of diversity, the same as race or gender, and, places the responsibility on society and governments for ensuring that political, legal, social, and physical environments support the full inclusion and participation of people with disabilities in making decisions that affect their lives (Lord et al 2007).

### 2.2.2 DISABILITY IN THE HUMAN RIGHTS CONTEXT

The entry into force of the Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol in May 2008 marked the beginning of a new era in efforts “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (Article 1 of the CRPD). Australia ratified the CRPD on 17 July 2008 and it entered into force for Australia on 16 August 2008. While technically, persons with disabilities have always been entitled to the full range of human rights, the CRPD marked the first time that their rights were set

out comprehensively in a binding international instrument.

The CRPD contains a specific article on women with disabilities that is cross-cutting, highlighting the importance it gives to recognising that the rights of women must be considered when interpreting and implementing every article of the CRPD (Article 6 of the CRPD). The CRPD also includes an article on freedom from exploitation, violence and abuse (Article 16 of the CRPD), which contains specific mention of age and gender-specific measures required to address the issue. Importantly, protecting and promoting the rights of people with disabilities is not simply about providing disability-related services, it also entails adopting measures to change attitudes and behaviours that stigmatise and marginalise persons with disabilities as well as putting in place the policies, laws and programs that remove barriers and guarantee the exercise of civil, cultural, economic, political and social rights by persons with disabilities (OHCHR 2010).

Although the CRPD does not include a definition of disability or persons with disabilities in the strict sense, it states that: “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1, CRPD). This definition does not preclude the use of definitions in national legislation, which may be necessary in some sectors such as employment or social security. However, according to OHCHR (2010), it is important that such definitions reflect the social understanding of disability enshrined in the CRPD and focus on the prohibition of discrimination and the promotion of equality, rather than on the categorisation of various disabilities based on impairments.

### 2.2.3 PREVALENCE AND IMPACT OF DISABILITY

The Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers* reports that 18.5 per cent of the Australian population has a disability, with 87 per cent of these people experiencing an impairment restricting core activity such as communication, mobility or self-care activities, or a restriction associated with schooling or employment (ABS 2010). The rate of disability increases with age with 88 per cent of people aged 90 years and over had a disability, compared with 7.2 per cent who are children aged 0-14 years (ABS 2010, ABS 2012). Physical conditions are most commonly associated with disability (84%), 11 per cent of disabilities are associated with mental or behavioural disorder, and 4.8 per cent with intellectual and developmental disorders (AHRC 2005).

Nationally, 50 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over had a disability or long-term health condition in 2008, with around 8 per cent having a profound or severe core activity limitation (ABS 2010). In non-remote areas, Aboriginal and Torres Strait Islander adults are one and half times more likely than non-Indigenous people to have a disability or long-term health condition and more than twice as likely to have a profound/severe core activity limitation (ABS 2010). Across gender, 48 per cent of Indigenous males have a disability as do 51 per cent of Indigenous females, with rates of disability increasing with age, ranging from 35 per cent of those aged 15-24 years compared to 80 per cent of people aged 65 years (ABS 2010). Comparison of disability rates for children aged 0-14 years showed a much higher rate of disability among Aboriginal and Torres Strait Islander children at 14 per cent than for non-Indigenous children at 7 per cent (ABS 2012).

It is widely acknowledged that fewer people with disabilities participate in the workforce than those without disabilities. Figures from 2003 indicated that only 53 per cent of people with disabilities participated in the labour force as compared to 81 per cent of those without a disability (AHRC 2005). Although the overall

employment rates for women have been increasing, employment rates for women with disabilities have decreased and they are also less likely to be in the workforce than men with disabilities (AHRC 2005). When employed, people with disabilities earn lower wages, on average, than workers without disabilities (ABS 2003). Having a disability reduced the average gross weekly wages of females by 24 per cent and males by 17 per cent in 1998, compared with people without disabilities (AHRC 2005). A recent report by the Australian Council of Social Services suggests that 27 per cent of people with disabilities live below the poverty line (ACOSS 2013). This evidence taken together demonstrates that the nexus between disability and poverty is intensified for women with disabilities, exacerbating the susceptibility of such women to experiencing violence.

### 2.2.4 LEGISLATIVE AND POLICY FRAMEWORK ON DISABILITY

At the national level, the legislative framework on disability includes the *Disability Service Act 1986* (Cth), the *Disability Discrimination Act 1992* (Cth) and the newly created *National Disability Insurance Scheme Bill 2013* (Cth), known as the National Disability Insurance Scheme (NDIS). This legislation is largely gender-neutral and lacks an overall human rights framing, in relation to the international human rights treaties Australia has ratified.

The *Disability Discrimination Act (DDA) 1992* (Cth) predates the CRPD, and although incorporates in part some of the obligations contained in the CRPD, is not comprehensive in this regard. The DDA establishes the legal right for people with disabilities to be free from discrimination and to participate in the community in the same way as people without disabilities. The DDA prohibits discrimination against people with disabilities in public spheres including employment, education, the provision of goods, services and facilities, and access to premises. It also allows people with disabilities to seek redress for individual circumstances of discrimination.

Disability services legislation is present at the Commonwealth and State/Territory levels. The *Disability Services Act (DSA) 1986* (Cth) provides a legislative and funding framework for a range of disability services, to assist people with disabilities to receive services 'necessary to enable them to work towards full participation as members of the community' and to assist them to achieve 'positive outcomes, such as increased independence, employment opportunities and integration in the community'. The DSA makes provisions for a set of guiding standards for the delivery of quality services known as the Disability Services Standards. The DSA, however, does not take specific account of gender and makes no provision for the disability services standards to be developed in a human rights context. Disability standards developed in 2007 are largely aimed at employment services, with others from 2012 aimed at advocacy services. Both these standards have been amended from the 1993 versions to include a standard on the protection of human rights and freedom from abuse. Most State and Territory Disability Services Acts were enacted in the early 1990s to give effect to the Commonwealth *Disability Services Act 1986*. Several jurisdictions have identified the need to review and update their Disability Services Acts as part of their implementation of the *National Disability Strategy 2010-2020*.

The newly created *National Disability Insurance Scheme (NDIS) Bill 2013* (Cth) aims to provide reasonable and necessary supports, including early intervention supports, for those deemed eligible. Its objectives include to 'give effect to certain obligations' to six of the seven international human rights treaties to which Australia is a party, including CEDAW and the CRDP, yet its gendered focus is limited and not as strong as would be expected to give effect to these treaties.

The national policy framework on disability is provided by the *National Disability Strategy 2010-2020* described in Section 2.1.2. This will be implemented through three implementation plans that seek to promote change by

governments and the broader community so that people with disabilities are provided with the needed supports to participate in all aspects of community life as full and equal citizens of the Australian society. One of the key actions of the *National Disability Strategy 2010-2020* is to implement the National Plan. Each State and Territory through their jurisdictional implementation plans will seek to provide lasting social change for promoting and protecting the dignity and human rights of all people with disabilities to ensure better outcomes for them beyond the life of the *National Disability Strategy 2010-2020*.

## 2.3 UNDERSTANDING VIOLENCE AGAINST WOMEN

Violence against women is understood as an issue of global concern that has serious impacts on the health and well-being of those affected, as well as significant economic costs to communities and nations (Hague & Sardinha 2010, Commonwealth of Australia 2009b). A 2013 World Health Organisation (WHO) multi-country study showed that violence against women is a 'global health problem of epidemic proportions', with more than one woman in three around the globe experiencing domestic/family violence and sexual violence (WHO 2013). The study found that intimate partner violence is the most common type of violence against women, affecting 30 per cent of women worldwide. Violence against women is generally a 'hidden' problem that takes place within private spheres such as home and other domestic arrangements. This 'invisibility' makes the problem difficult to determine, as women who are affected are often emotionally involved with, or economically dependent on perpetrators, making it difficult for them to disclose their experiences or seek help (Castelino & Whitzman 2008).

### 2.3.1 DEFINITIONS OF VIOLENCE AGAINST WOMEN

In Australia, there is no uniform definition or consensus as to what constitutes violence against women (ABS 2006). It is generally understood in the context of 'domestic', 'spousal' or 'family' violence. There is no consistency across the varying jurisdictions, with the laws in each State and Territory containing different definitions (Frohman & Swift 2012). The National Plan adopts the following definition from the 1993 United Nations *Declaration on the Elimination of Violence Against Women* which defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations 1993).

According to the National Plan, 'domestic violence' refers to acts of violence that occur between people who have, or have had, an intimate relationship, with the central element of domestic violence being an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening (Commonwealth of Australia 2010). In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal (Commonwealth of Australia 2010). The National Plan identifies forms of domestic violence to include physical, sexual, emotional, and psychological abuse. Such violence can include:

- physical violence which includes slaps, shoves, hits, pushes, being thrown down stairs or across the room, kicking, twisting of arms, choking, and being burnt or stabbed;
- sexual assault or sexual violence which includes rape, sexual assault with

implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator; and

- psychological and emotional abuse which includes a range of controlling behaviours such as control of finances, isolation from family and friends, continual humiliation, threats against children or being threatened with injury or death (Commonwealth of Australia 2010: 2).

For the Indigenous community in Australia, the term 'family violence' has a broader and more encompassing definition than that used in the mainstream in order to encompass a wide range of physical, emotional, sexual, social, spiritual, cultural and economic abuses that occur within intimate relationships, families, extended families, kinship networks and communities (VicHealth 2011). According to the National Plan, 'family violence' refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as domestic violence, and as with domestic violence, only some aspects of family violence are criminal offences. However, according to the National Plan, "any behaviour that causes victims to live in fear is considered unacceptable" (Commonwealth of Australia 2010: 2).

### 2.3.2 VIOLENCE AGAINST WOMEN IN THE HUMAN RIGHTS CONTEXT

Violence against women is considered as one of the most widespread violations of human rights worldwide (UNGA 2012) and is now at the forefront of the international agenda as a human rights issue requiring national government and international action (CSW 2013). In December 1993, the UN General Assembly adopted the *Declaration for the Elimination of Violence against Women*, and in March 1994, the UN appointed a Special Rapporteur on Violence Against Women, with a mandate to investigate and report on all aspects of violence against women (CSW 2013).

According to the UN Human Rights Council, violence against women is a crime and a human rights violation that occurs, often repeatedly, in the lives of a great number of women around the world, and is rooted largely in the lack of equality between men and women (HRC 2011a). Although the forms of violence experienced may differ depending on cultural or socio-economic standing, there are aspects of such violence that are universal, with most acts of violence frequently taking place at home within the family circle (INWWD 2011). The privacy of such acts of violence when it takes place within the home and the societal tolerance for gender-based violence within the private sphere contributes towards making it difficult to detect or invisible (INWWD 2011).

The United Nations recognises violence against women as a violation of women's rights and fundamental freedoms as human beings. Violence affects women's entitlements to equality, security, liberty, integrity and dignity in political, economic, social, cultural and civil life (United Nations 1993). Despite these developments, the global discourse on women's human rights has been largely restricted to a framework of equality and non-discrimination against women versus men, leaving challenges in analysing intra-gender differences among women (HRC 2011b). This has meant that the specific circumstances of women with disabilities have not been well articulated or incorporated into the discussions/discourse on violence against women.

Australia was among the first countries to sign the *UN Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW) on 17 July 1980, and it entered into force for Australia on 27 August 1983. Recognising Australia's obligations under CEDAW, and in an effort to combat persistently high levels of violence against women, the Australian Government established the National Council to Reduce Violence against Women in 2008 and formulated the 12-year strategy, the *National Plan to Reduce Violence against Women and their Children 2010-2022*, which are seen as

significant steps towards addressing violence against women and surrounding issues in Australia (CEDAW 2012). According to the then Minister for the Status of Women, the Hon Julie Collins, at the heart of the National Plan is the recognition that "only sustained, united action across generations, and jurisdictions, will achieve enduring change" (Collins 2013). The National Plan considers violence against women as a fundamental breach of human rights in Australia (Commonwealth of Australia 2010). It places strong emphasis on primary prevention and community engagement, and recognises the critical role of men and boys in eliminating violence against women and girls (Collins 2013).

### 2.3.3 PREVALENCE AND IMPACT OF VIOLENCE AGAINST WOMEN

In Australia there is no national mechanism for collection of data on violence against women (AHRC 2012b). Usually, the first to respond to individual incidents of violence against women are health care providers and the police. However, there appear to be no mechanisms in place for the collaborative collection or collation of data from these sectors to inform and direct effective policies on the issue. The available national data on the issue comes from a series of data sources including the International Crime Victims Surveys conducted in 1989 and 2004, the *1996 Women's Safety Survey*, the *2002-2003 International Violence Against Women Survey*, the *2005 Personal Safety Survey* and the *2009 National Community Attitudes Survey* (Posselt 2005, VicHealth 2011). Findings from these surveys suggest that the most pervasive forms of violence against women are sexual assault and domestic and family violence (Commonwealth of Australia 2009a).

A report by the UN Special Rapporteur on Violence against Women suggests that one in three women in Australia experience physical violence and almost one in five women experience sexual assault (HRC 2011b). Of



those women who experience physical violence, 85 per cent are assaulted by a current or former partner, family, friend or other known male; and three quarters of these physical assaults occur in the woman's home (HRC 2011b). Research also shows that domestic and family violence is the leading contributor to death, disability and illness in women aged 15 to 44 years. The effects of violence also cause significant losses to the Australian economy through absenteeism, lack of participation and lost productivity (VicHealth 2011, Commonwealth of Australia 2009b).

Studies show that although violence against women has no geographical, socio-economic, age, ability, cultural or religious boundaries, some groups of women are more at risk of violence than others (Commonwealth of Australia 2010). These studies have found that young women experience violence at higher rates than older women. Twelve per cent of women aged between 18 and 24 years have experienced at least one incident of violence, compared to 6.5 per cent of women aged 35-44 years and 1.7 per cent of women aged 55 years and over (ABS 2006). In Australia, despite representing just over 2 per cent of the total population, Aboriginal and Torres Strait Islander women are 45 times more likely than non-Aboriginal and Torres Strait Islander women to be victims of domestic and family violence and, 35 times more likely to be hospitalised as a result of family violence-related assaults than non-Indigenous women (HRC 2011b).

Research suggests that some of the contributing factors to violence against women in Australia include structural gender inequalities; the failure to acknowledge the culture of violence against women in Australia; the tendency to blame women for their experiences of violence; inadequate refuges and housing; insufficient resources and capacity to address violence; inadequate collaboration, integration and uniformity across government departments; lack of comprehensive collation and disaggregation of data; and a lack of understanding as to whether the increase in reporting of domestic violence suggests greater prevalence or greater awareness of the issue (HRC 2011b). Individual

level factors such as alcohol and drug use or childhood exposure to violence were found to be neither necessary nor sufficient conditions for violence against women to occur. However, these factors were seen to exacerbate the frequency or severity of violence, but only when they occur in conjunction with the key determinants related to gender norms, gender inequality and gender power disparities (VicHealth 2011).

### 2.3.4 LEGISLATIVE AND POLICY FRAMEWORK ON VIOLENCE AGAINST WOMEN

Australia does not have coordinated national family/domestic violence legislation. The National Plan however, provides a single, unified strategy that brings together government efforts to reduce violence against women. The legal framework is provided by the Family Law Act 1975 (Cth) which provides for the protection of children who are exposed or subjected to family violence. It is usually at the State and Territory level that protections are applied for women affected by violence. Commonwealth, State and Territory criminal laws and child protection laws also impact upon violence against women. As part of the preparatory activities for the development of the National Plan, the National Council to Reduce Violence against Women requested the Australian Law Reform Commission (ALRC) in 2010 to inquire into and report on the treatment of family violence in the *Family Law Act*. The ALRC was asked to consider the issues of:

- i) the interaction in practice of State and Territory family/domestic violence and child protection laws with the *Family Law Act* and relevant Commonwealth, State and Territory criminal laws and child protection laws; and
- ii) the impact of inconsistent interpretation or application of laws in cases of sexual assault occurring in a family/domestic violence context, including rules of evidence, on victims of such violence.



As a result, the ALRC recommended that the definition of family violence in domestic legislation should include:

- conduct that is violent, threatening, or coercive and controlling, or intended to cause a family member to be fearful; and
- a non-exhaustive list of examples of physical and non-physical conduct (WWDA 2012).

The ALRC also further recommended that in order for women affected by violence to receive adequate, appropriate and timely protection, a number of other legislation, including those on social security and child support, needed to be revised to include a consistent definition of family violence (Commonwealth of Australia 2011a: 11). In 2011, the *Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011* amended the *Family Law Act* to prioritise children's safety in parenting arrangements and to reduce any disincentives to disclosing family violence (ADFVC 2013).

Although gender equality and the prevention of violence against women is an obligation under a number of international human rights treaties ratified by Australia, the National Plan is only linked to CEDAW, and so is primarily focused on meeting human rights obligations in relation to gender discrimination. Whilst CEDAW is a critical part of the underlying human rights framework of the National Plan, prevention of violence against women is equally a key obligation relating to civil and political rights; economic, social and cultural rights; disability rights; child rights; as well as rights to be free from torture (and other cruel, inhuman or degrading treatment or punishment); and racial discrimination. This deficit was highlighted by the Committee on Economic, Social and Cultural Rights in 2009 in their Concluding Observations to Australia, which recommended that future Action Plans developed under the existing National Plan should be strengthened by clearly articulating them in a comprehensive human rights framework and policy context (CESCR 2009).

The implementation of the *Australian National Action Plan on Women, Peace and Security 2012-2018* is expected to significantly contribute towards reducing violence against women (AHRC 2012b). This Action Plan is guided by five key thematic areas for conceptualising and organising activities in the implementation of the Australian Government's Women, Peace and Security agenda: prevention; participation; protection; relief and recovery; and normative. It uses a whole of government approach to integrate a gender perspective into Australia's peace and security efforts, protect women and girls' human rights, and promote their participation in conflict prevention, management and resolution (AHRC 2012b).

## 2.4 UNDERSTANDING VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES

As the National Plan indicates, violence against women affects different groups of women and children differently, and women and girls with disabilities have been identified as a group that are at significantly higher risk of violence (Commonwealth of Australia 2010). Although women and girls with disabilities experience the same forms of violence as other women and girls, they also experience forms of violence that are particular to their situation of social disadvantage, cultural devaluation and increased dependency (Chenoweth 1997, Swift 2013). Research shows that women and girls with disabilities are also at greater risk of violence, exploitation and abuse than men with disabilities or other women (INWWD 2011).

In understanding violence against women and girls with disabilities, it is also important to consider the specific intersections that some women and girls with disabilities face due to the place and space they occupy in society. Poverty, race, ethnicity, religion, language and other identity status or life experiences can further

increase the risk of group or individual violence against women and girls with disabilities (Ortoleva and Lewis 2012). In the Australian context, women and girls with disabilities living in rural and remote communities are particularly disadvantaged as a result of the inaccessible environments and lack of services, information, awareness and education. While disability support and violence support services are much needed in such communities, these are often seen as secondary to more basic needs such as provision of nutritious food, shelter, and security; and often it is difficult to get outsiders to move to remote communities to provide these services (Commonwealth of Australia 2011b). As a result, women and girls with disabilities in such locations are more susceptible to violence, exploitation and abuse with few supports available to seek redress. Since rural and remote communities often have high proportions of Indigenous women and girls with disabilities this group is particularly at risk.

The criminal justice system is a space in which the connections between gender, disability, violence and social disadvantage are particularly evident. The majority of women in the criminal justice system have been diagnosed with mental ill health and/or trauma, and the majority have a history of childhood violence and/or adult domestic violence (Stathopoulos 2012). Therefore as a space, the criminal justice system and specifically the prison have concentrations of women with psychosocial disability and who have experienced violence. Empirical research on women with cognitive and psychosocial disability in the criminal justice system is limited, but that which is available suggests a number of key characteristics of this group and their experiences. One is the significance of violence and trauma, both as children and adults and in institutional and intimate relationships. Another is the significance of complex social marginalization, including childhood disadvantage and homelessness. Indigenous women with cognitive and psychosocial disability in the criminal justice system are known to be particularly disadvantaged (Baldry, McComish, and Clarence 2009; Baldry, Dowse,

and Clarence 2012). As well as the conditions of social disadvantage and histories of violence and abuse that are evident in the lives of women with disabilities who come into contact with the criminal justice system, the disabling impacts of incarceration itself are also significant (Dowse, Baldry and Snoyman 2009). Limited capacity for appropriate response by various actors in the criminal justice system to women with disabilities experiencing violence have also been identified as problematic. Poor recognition of disability and limited mechanisms for supporting women to access and participate in legal processes currently exists at multiple levels in the criminal justice system including front line policing, reporting and prosecution processes in legal and court proceedings (Dowse, Frohmader and Meekosha 2010).

Cultural attitudes are also known to impact certain groups of women and girls with disabilities from seeking help or being able to access existing services and supports. Women and girls from culturally and linguistically diverse (CALD) backgrounds may lack understanding of the issue in addition to experiencing language barriers which may prevent access to mainstream services. Few specialist services exist for CALD women and girls with disabilities across Australia. The attitudes of service providers also play a vital role for women and girls with disabilities who are lesbian, bisexual, transgendered or intersex (LGBTQI) and who are affected by violence. Similarly, power differentials in institutional settings may make women and girls with disabilities who are in health-related, disability-related, age-related, or criminal justice institutions more susceptible to violence, exploitation and abuse, which is further compounded by their reliance on both informal and formal supports and carers within these settings.

#### **2.4.1 DEFINITION OF VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES**

Women and girls with disabilities are subject to many forms of violence, including domestic and family violence, sexual assault, as well as

violence committed against them in institutional settings, and other forms of violence including forced sterilisations and abortions (Broderick 2012). They are particularly at risk of violence when perpetrators are carers who are in a position of control and power and when they are co-residents in accommodation services (VicHealth 2011). Women and girls with disabilities also experience violence that is specific to the nature of their disability. This can include, for example, denial of mobility and communication devices, withholding of food or medication, threats of institutionalisation, threats to, and/or abuse of support or assistive animals (Cockram 2003, WWDA 2007) or restraining a person in order to administer non-prescribed medications or exploiting a woman in order to access her service support (Dillon 2010). Global studies suggest that women and girls with disabilities are twice as likely to experience domestic violence and other forms of gender-based and sexual violence as women without disabilities, and are likely to experience violence over a longer period of time and to suffer more severe injuries as a result of the violence (Ortoleva & Lewis 2012).

There is no agreed definition of violence against women and girls with disabilities in Australia. Due to the pervasive nature of the types of violence and the injustices they experience, it has been difficult to narrow it down to a concise definition (WWDA 2004). However, violence against women and girls with disabilities include physical, sexual, and emotional violence and abuse as well as institutional violence, chemical restraint, drug use, forced or coerced sterilisation, forced contraception, forced or coerced psychiatric interventions, medical exploitation, violations of privacy, humiliation, and harassment (WWDA 2010, WWDA 2004, Chenoweth, 1997). In addition to physical, mental and sexual violence and abuse, women and girls with disabilities also face unnecessary institutionalisation, denial of control over their bodies, lack of financial control, denial of social contact, employment and community participation (INWWD 2011, WWDA 2010, Cattalini, 1993).

#### **2.4.2 VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES IN THE HUMAN RIGHTS CONTEXT**

Since Australia has ratified a number of human rights treaties including the CRPD, it is the responsibility of the Australian Government to ensure that people with disabilities are not subject to any form of violence, exploitation or abuse so that they enjoy all their human rights. This requires the Australian government to protect and fulfil the rights of women and girls with disabilities to ensure freedom from violence, exploitation and abuse in addition to freedom from torture and other cruel and inhuman or degrading treatment. This requires active strategies to both prevent human rights abuses and also guarantee these freedoms; not merely abstaining from taking measures that might have a negative impact. It also requires the government to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to women and girls with disabilities so that they may enjoy their human rights (WWDA 2011).

Women and girls with disabilities are at high risk of gender-based and other forms of violence based on social stereotypes and biases that attempt to dehumanise or infantilise them, exclude or isolate them, target them for sexual and other forms of violence, and put them at greater risk of institutionalised violence (Ortoleva & Lewis 2012). A combination of factors at the societal and individual level, such as exclusion from participation in community life due to prejudices, stigma and discrimination, lack of access to quality education, employment and livelihood, as well as access to healthcare and other support services and resources, result in marginalisation, disempowerment, dehumanisation and the systemic denial of the rights of women and girls with disabilities (Nguyen 2012).

Women and girls with disabilities frequently do not report the violence they experience as institutions of justice are often not accessible and do not provide reasonable accommodation

for women with different types of impairments (Ortoleva & Lewis 2012). Women and girls with disabilities also lack access to legal protection and representation, and law enforcement officials and the legal community are generally ill-equipped to address the violence. The testimony of women and girls with disabilities may not be viewed as credible by the justice system. Furthermore, lack of access to information in appropriate formats leaves women and girls with disabilities marginalised within the justice system (Ortoleva & Lewis 2012). This in turn may heighten their risk of being seen by perpetrators as 'ideal victims' as they are either unable to report violence or not believed when they do so (Lund 2012).

#### **2.4.3 PREVALENCE AND IMPACT OF VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES**

There is limited data and research available on the prevalence and nature of violence against women and girls with disabilities (AHRC 2012a). Readings of possible incidence may be taken against the incidence of violence in the broader population of women and combined with the known increased risk of violence to women and girls with disabilities. Women and girls with disabilities make up about 20 per cent of the population of Australian women, equating to about two million people, or 9.5 per cent of the total population (Broderick 2012, DRALHRO 2012). Although there is evidence that women and girls with disabilities are more likely to experience domestic violence, the full extent of violence experienced by them is unknown (Mitchell 2011). Due to their situation of social and cultural disadvantage and increased dependence, women and girls with disabilities are expected to be particularly vulnerable to physical, sexual and psychological violence (Mitchell 2011). PWDA (2013) reports that women and girls with disabilities were 37.3 per cent more likely than women and girls without disabilities to experience some form of intimate partner violence, with 19.7 per cent reporting a

history of unwanted sex compared to 8.2 per cent of women and girls without disabilities.

Thirty-one per cent of Australians live in rural areas, and it is believed that almost 700,000 women and girls with a disability live in rural and remote Australia (Broderick 2012). Only 16 per cent of all women with disabilities are likely to have any secondary education, and men with disabilities are twice as likely to be in paid employment as women with disabilities (PWDA 2013). According to the Australian Productivity Commission, disability affects Indigenous Australians at a rate that is 2.2 times higher than non-Indigenous Australians, affecting 26,000 people, a large majority of whom live in highly isolated remote communities (Commonwealth of Australia 2011b). These additional factors of social and geographic disadvantage compound the likelihood and effects of experiences of violence faced by many women and girls with disabilities in Australia (WWDA 2011).

The main indicators on incidence of violence against women in the Australian context come from the ABS *1996 Women's Safety Survey* and the *2005 Personal Safety Survey* (PSS) which collected information about both women's and men's experiences of violence (WWDA 2011). Both these surveys provide limited information about the extent of violence against women and girls with disabilities (Mulroney 2003, Flood 2006). Results of the 2012 PSS are expected to be released in late 2013. The lack of national studies or research conducted in this area makes it difficult to establish the true prevalence, extent, nature, causes and impact of violence against women and girls with disabilities in different settings. The lack of accurate data at all levels of government is one of the greatest difficulties in determining and substantiating the needs and human rights violations of women and girls with disabilities in Australia.

Most services in Australia do not routinely collect data on disability and violence. The Australian Institute of Health and Welfare collect a number of Minimum Data Sets (MDS), which is a regular national collection of information

about clients and the services they receive. There are three MDS data collections which are of relevance to women and girls with disabilities who are experiencing violence. They include the Home and Community Care Minimum Data Set (HACC MDS), the Disability Services Minimum Data Set (DS MDS), and the Specialist Homelessness Services National Minimum Data Set (SHS NMDS). The HACC MDS collects information such as age, living arrangements, and the amount and types of assistance being provided; the DS MDS gathers data centred on the service user and their experiences including the amounts and types of services they receive; and the SHS NMDS gathers information about people who are either homeless or at risk of homelessness and who are seeking services from specialist homelessness and emergency services. Potential sources of data on violence against women and girls with disabilities such as that collected through the National Disability Abuse and Neglect Hotline (WWDA 2011) are not publicly available for analysis. The failure to utilise these types of data constitutes a missed opportunity for the development of informed policy and programs related to violence against women and girls with disabilities.

The 2009 *National Community Attitudes towards Violence against Women Survey* (NCAS), for the first time, included a limited number of questions on violence against women with disabilities. The findings from this survey suggest that community awareness of violence against women and girls with disabilities is very poor, with few respondents recognising the greater vulnerability of women and girls with disabilities to violence compared to other women (WWDA 2011). Preparations for the 2014 NCAS are currently underway, and it is expected that this survey would include better coverage of questions on violence against women and girls with disabilities.

The need for Governments to accelerate their efforts in research and data collection has been re-iterated by the United Nations Human Rights Council in its Resolution A/HRC/14/12 of 23 June 2010. This is also reflected in

the CEDAW Committee's 2010 Concluding Observations to Australia which stated that a comprehensive assessment of the situation of women with disabilities in Australia should be undertaken, and recommended that the Australian government, as a matter of priority, address the violence and abuse experienced by women with disabilities living in institutions or supported accommodation (CEDAW 2010). The National Council to Reduce Violence against Women in its plan, *Time for Action*, identified data collection as a key issue for women and girls with disabilities who experience violence and abuse (FaHCSIA 2009). To address this, the Australian Government plans to conduct two national surveys every four years: the *Personal Safety Survey* and the *National Community Attitudes Survey* (CEDAW 2012). These surveys have the potential to provide valuable data about experiences of, and attitudes towards, violence against women and girls with disabilities.

Data, research and information about women and girls with disabilities is necessary to develop and inform policy, direct resources, inform service development, and design and monitor specific programmes in the area. It is a critical tool for accountability, for enhancing the participation of women and girls with disabilities in the planning and implementation of effective services, and for monitoring progress towards the achievement of their economic, social, political and cultural rights.

#### **2.4.4 LEGISLATIVE AND POLICY FRAMEWORK ON VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES**

In Australia, there is no specific legal, administrative or policy framework for the prevention, protection, investigation and prosecution of violence, exploitation, and abuse of women with disabilities. No existing Commonwealth or State/Territory domestic and/or family violence legislation is framed in a human rights framework setting it in the context of Australia's obligations under



the international human rights treaties it has ratified. The Commonwealth *Family Law Act 1975*, amended in 2011 through the *Family Law Legislation Amendment (Family Violence and Other Measures) Bill 2011*, contains no overarching objects or principles, and is not set in a human rights framework. The only amendment made in 2011 relating to human rights was the inclusion of an object at sub-section 60B relating to children.

The 2010 ALRC *National Inquiry into Family Violence* recommended that Commonwealth, State and Territory family violence legislation should contain guiding principles and objects that clearly reference a human rights framework, in order to: give effect to Australia's international human rights obligations, serve as an educative function and, aid in the interpretation of the legislation drawing upon all applicable international human rights instruments. In addition, the ALRC recommended that human rights based family violence legislation should acknowledge the gendered nature of violence and recognise that family violence has a particular impact on marginalised and vulnerable groups, including people with disabilities, Indigenous persons; those from a CALD background, those from the LGBTIQI communities, and older persons.

The ALRC recommendations suggest that State and Territory family violence legislation should address the following aims:

- to prevent or reduce family violence and the exposure of children to family violence;
- to ensure or maximise the safety and protection of persons who fear or experience family violence; and
- to ensure that persons who use family violence are made accountable for their conduct (ALRC 2010).

It is expected that a comprehensive legislative approach, based on a human rights framework, would encompass not only the criminalisation of all forms of violence against women and

the effective prosecution and punishment of perpetrators, but also the prevention of violence, and the empowerment, support and protection of survivors. Prioritising prevention in legislation would include provision for a range of measures including for example: awareness-raising campaigns, education and sensitisation of the media, information on human rights and violence against women and girls (including those from marginalised and vulnerable groups) at all levels of educational curricula, and through awareness and promotion of the safety of women in public spaces and in cyberspace (UN Women 2011).

Currently domestic and family violence legislation in different States and Territories provide different levels of protection and definitions of what constitutes 'family violence' and what constitutes a 'domestic relationship'. Broader definitions include residential settings, such as group homes and institutions, where women with disabilities often live and interact domestically with co-residents, support workers and service managers (DRALHRO 2012). However, even where there are broader definitions, domestic and family violence legislation is rarely utilised, largely because violence perpetrated against women and girls with disabilities in residential settings is rarely characterised as domestic/family violence and rarely are domestic violence related interventions deployed to deal with this type of violence (Frohman & Swift, 2012). Where narrower definitions apply, there is a high risk that women with disabilities who live in residential settings are excluded from these protections.

The greatest incidence of violence experienced by women with disabilities occurs within the private sphere. The DDA and other State and Territory anti-discrimination legislation has limited scope in relation to this violence. This is also the case for violence occurring within publicly funded institutions providing accommodation for women with disabilities such as group homes, institutions and boarding houses, as well as prisons, as these are largely conceptualised as being within the private sphere, that is, domestic arrangements which are publicly funded.



Moreover, many women with disabilities face significant barriers or disincentives to using the complaints processes available within disability specific legislation. For example, many women with disabilities lack an awareness of the DDA or find that the complexity and potential formality of the process is cumbersome and difficult to negotiate. Other factors such as the fear of victimisation; the onus on the complainant to prove their complaint; the abuser also acting as the primary carer while additional support is lacking; the unequal financial and legal resources of complainants and respondents; the financial and non-financial costs involved; and, the lack of support and assistance in preparing for, and going through the process, further deter women with disabilities who have experienced violence from participating in the system to seek redress for acts of violence perpetrated against them (APC 2004, WWDA 2009).

Similarly, the Disability Services Standards are limited as a mechanism to address violence against women and girls with disabilities. The Standards generally do not contain qualification relating to gender and focus on 'abuse and neglect' rather than identifying 'violence'. Furthermore, issues identified with the Standards include that they rely on service providers having a working knowledge of what constitutes violence against women and girls with disabilities; are essentially adult focused, and are concerned primarily with the collection of quantitative data rather than incorporating in-depth qualitative reporting methods for service recipients, which would be more likely to reveal experiences of violence (WWDA 2011).

National Disability Insurance Scheme, currently in development and early implementation, presents both risks and opportunities in relation to recognising and addressing violence against women with disabilities. A Senate Inquiry into the Draft NDIS Bill, which received more than 1,600 submissions and also included 11 public hearings, resulted in amendments to the Bill, which included significant strengthening of the objects in relation to Australia's human rights obligations under the international human rights

treaties Australia has ratified. Another significant amendment to the NDIS Bill, as a result of the Senate Inquiry, saw the inclusion of gender into its principles, reflecting that the CRPD specifically recognises the position of women and girls with disabilities and the multiple discrimination they face (CALC 2013).

Whilst the strengthening of the NDIS Bill 2013 to incorporate a stronger human rights framework is a positive development, there is concern with the omission of the term 'violence' from its principles Clause. The General Principles' guiding actions under the Bill include that "people with disability have the same right as other members of Australian society to respect for their worth and dignity and to live free from abuse, neglect and exploitation". Article 16 of the CRPD however, indicates that States Parties "shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, *violence* and abuse, including their gender-based aspects".

Omission of the word 'violence' from the principles of the NDIS Bill may seem, on face value, relatively inconsequential. However, it has been widely acknowledged that the use of the term 'abuse' instead of 'violence' can serve to minimise the severity of crimes perpetrated against people with disabilities and can be used to de-criminalise or trivialise serious offences (WWDA 2007). Using the terms 'abuse', 'neglect' and 'exploitation' instead of 'violence' can provide a rationale for reclassifying violence (particularly violence committed within services and institutions that are conceptualised as 'domestic/private sphere') into 'administrative infringements'. This risks making violence perpetrated against women and girls with disabilities invisible and can result in poor or service inappropriate responses.

Additionally, although the NDIS Bill presumes that participants in the NDIS are able to be involved in the decision-making themselves, it provides for the appointment of 'nominees' on

behalf of those participant unable to do so. This dependency on a 'plan' or 'correspondence' nominee raises issues of serious concern regarding exposure of individuals to risks of abuse from their 'nominees'. It is crucial for a scheme that aims to increase people with disabilities' individual choice and control to put in place quality control mechanisms with respect to service providers. In the absence of good peer referrals or advocacy, it is possible for abuses of freedom, neglect and other abusive practices to occur.

Without appropriate and inclusive legislation, there are limited legal means to address violence against women and girls with disabilities. Legislation has the potential to

demonstrate that violence against women and girls with disabilities is a public issue, not a private concern. Definitions in family violence legislation are critical, because they set the scope for who is covered and under what circumstances. Causes, interventions and prevention strategies are contingent upon the validity of the definitions available (WWDA 2007). They also provide the benchmark for translation into relevant policy frameworks, policies and service responses. The lack of effective recognition across the legal system results in poorer protection for women and girls with disabilities and less likelihood of such women and girls benefiting from integrated and coordinated responses and prevention.



## 3 INFORMATION GATHERING PROCESSES AND OUTCOMES

### SUMMARY POINTS

A range of strategies have been used to build the evidence-base for the Stop the Violence Project.

#### DESK-BASED REVIEWS

- A review of research literature nationally and internationally to identify key issues relevant to understanding and addressing violence against women and girls with disabilities.
- Analysis of existing legislation and policy to map structural and systemic issues in a rights-based approach to violence against women and girls with disabilities

#### STAKEHOLDER ENGAGEMENT AND CONSULTATIONS

- Regular consultations with the Project Steering Group consisting of high-level policy officials from each State and Territory Government agency with responsibility in the area, as well as key representatives of the non-government women's and disability sectors including National Disability Services (NDS), the Australian Council of Social Services (ACOSS), the Australian Women Against Violence Alliance (AWAVA) and Children with Disability Australia (CDA). The PSG is chaired by the Sex Discrimination Commissioner of the Australian Human Rights Commission.
- Advice from an Expert Consultative Group consisting of experts from relevant fields of research and advocacy with interest and experience in issues relating to violence prevention and responses for women and girls with disabilities.

- Two forums with women with disabilities to tap their experiences and expertise in identifying measures and strategies to enable women and girls with disabilities to be equal and active participants in violence prevention and response policy and practice. Key issues emerging from these forums include:
  - the need for States and Territories to develop and legislate on an agreed definition of domestic/family violence before a national strategy or solution is achieved;
  - a lack of representation of the needs of women with disabilities on violence prevention and response agendas;
  - agencies, including disability services, having the capacity to effectively respond to the presence of violence against women and girls with disabilities in its various forms and contexts;
  - lack of meaningful data collection around violence and women with disabilities;
  - unhelpful responses from police; and
  - better recognition of the 'credibility' of women with disabilities, especially in the law.

#### NATIONAL SURVEY

- Information was collected through an online survey targeted at service providers, representative organisations and policy makers across all jurisdictions regarding the work that they do, their knowledge and experiences of the policies and legislative frameworks that guide their work, and the challenges

they face in responding to the needs of women and girls with disabilities experiencing or at risk of violence.

- A total of 367 agencies responded to the survey; 279 of these were service providers, 34 were policy development agencies and 54 were representative organisations. The high rate of participation in the survey is suggestive that violence against women and girls with disabilities is recognised in the field as a significant issue warranting attention.
- The sample captures organisations operating in urban, regional and remote areas within all States and Territories, as well as organisations that operate federally.
- A high proportion of Australia's human services/welfare sector is represented by service provider respondents. With 122 domestic violence and sexual assault service providers and 102 disability service providers, the sample approaches saturation of these two populations. Other human service sectors such as housing/homelessness, health and mental health, youth welfare and family and relationship services are also represented.
- Service provider respondents were active in a range of areas including individual case management, community access, information, advice and referral services, violence prevention, counselling and mental health services, outreach, court support, in-home support, safe-at-home services and crisis accommodation.
- 82 per cent of these organisations provide services to women and girls with disabilities, therefore, the respondents were well placed to provide accurate and meaningful information about the challenges and complexities of meeting the needs of women and girls with disabilities experiencing or at risk of violence.

### 3.1 DESK-BASED RESEARCH AND ANALYSIS OF LEGISLATION AND POLICES

Review of current literature from Australia and internationally have been undertaken to draw out contemporary understandings of disability and of violence against women, and how these intersect and impact on women and girls with disabilities. The increased risks that women and girls with disabilities face due to the intersections of gender and disability and its location within legislative and service frameworks is highlighted. Analysis of the international human rights framework, particularly in terms of Australia's obligations and how they impact on women and girls with disabilities is combined with an analysis of the national and state and territory level legislation and policy context for preventing and addressing violence against women and girls with disabilities. The relationship between Australia's international obligations in the area and how these are, or not, embedded in domestic legislation has been examined. These materials are presented as the Background to the Issue in Section 2 of this paper.

### 3.2 STAKEHOLDER ENGAGEMENT AND CONSULTATIONS

A comprehensive range of stakeholders have been engaged in the project through a nationally distributed survey of service providers, policy makers and representative agencies, the constitution of an expert consultative group and targeted consultations with groups of women with disabilities.

#### 3.2.1 STAKEHOLDER MAPPING

Key informant scoping was carried out with extensive input and advice from the members

of the PSG (see Section 1.4 for description and composition) and through various networks in order to ensure inclusion and capture of data in the national survey from all relevant policy makers, representative organisations and service providers across all sectors and jurisdictions in Australia involved in providing services for women and girls with disabilities. Stakeholders relevant to the area were identified and mapped across service sectors including disability, domestic violence and sexual assault, child welfare, criminal justice, legal services, women's services, police, health and mental health, housing and homelessness, information, advice and referral services, Aboriginal and Torres Strait Islander support services, residential and non-residential aged care, and services for people from CALD backgrounds.

### 3.2.2 EXPERT CONSULTATIVE GROUP

The STVP has sought advice from a targeted group with expertise and interest in issues relating to violence prevention and responses for women and girls with disabilities. These experts come from a range of fields including, disability, violence against women and girls, criminal justice, health and mental health and child protection. They have provided input into the development, piloting and distribution of the national survey, assisted with consultative forums held for women with disabilities (see Section 3.2.3) and provided advice on the content of this Background Paper.

### 3.2.3 CONSULTATIONS WITH WOMEN WITH DISABILITIES

The inclusion and participation of women and girls with disabilities in directing their own lives is a strong underpinning principle of the STVP and has been enacted through targeted consultations with women with disabilities. Two forums were conducted with women with disabilities with the specific aim of harnessing experience and expertise in identifying measures and strategies

to enable women and girls with disabilities to be equal and active participants in violence prevention and response policy and practice.

## CONSULTATION PROCESS

The forums were hosted by two established State-based local networks of women with disabilities in Melbourne, (VIC) and Brisbane, (QLD) on the 11 and 12 April 2013 respectively. The two networks: Women with Disabilities Victoria (WDV) and Queenslanders with Disabilities Network (QDN) were selected on the basis of their expertise in the area of disabilities and gender, and because their executive officers were also members of the ECG, and therefore had an understanding of the current project. In addition, there are significant differences between the two networks and their current levels of engagement with policy-makers and service providers and it was hoped that this divergence would provide comparative information for analysis. WDV is a funded network with paid staff, and is relatively well-known to the government and the domestic violence sector for its expertise, advocacy, research and project work in relation to violence and women with disabilities. On the other hand, the QDN is an unfunded organisation that relies on the support of its network to engage in activities and project work, which as a result occur on a comparatively ad hoc basis.

Invitations were prepared in both Standard and easy English and distributed through organisational networks. Potential participants were provided background information on the STVP and its objectives. All participation and support requirements for attendees were canvassed at application and any identified support was provided during the forums. The participants included women with a range of disabilities and brought a range of perspectives and experiences, with representation from Indigenous, LGBTIQI and culturally diverse women with disabilities. Women from both urban and regional locations were represented.

The expertise assembled in the forums was evident by the organisational and activist affiliations of the participants which included women currently serving as board members in community, social, health and disability organisations, with others identifying as active campaigners for disability rights.

Discussion addressed how women with disabilities can engage and be active in:

- developing and implementing violence and response policies
- designing, delivering and evaluating services that aim to prevent and respond to violence
- defining the issues of concern, making decisions and taking action to achieve change.

## CONSULTATION OUTCOMES

A range of both common and localised issues were identified through the consultation forums. The participants in Victorian forum identified numerous pilots, initiatives, services, systems and practices that they felt worked well and the principles of which they suggested should be continued, extended or replicated. These included important amendments to the *Victorian Family Violence Protection Act* to encompass a broader more realistic definition of 'family like' relationships, protection of women via exclusion orders and recognition by Victorian Police of violence against women with disabilities as more than simply a 'family matter'. Participants also identified the Common Risk Assessment Framework (CRAF) used by maternal and child health nurses, and a number of innovative pilots and projects in Victoria such as *Safe Futures*, *Making Rights Reality* and *Koori Women Mean Business* as promising models of good practice.

The women in Queensland had more difficulty generating examples of what currently worked well in their State but identified several positive developments including: Australia endorsing

the outcomes of the 2013 UN Committee on the Status of Women (CSW) which acknowledged the issue of violence and women with disabilities; the service Women Working alongside women with Intellectual and Learning Disabilities (WWILD) in Brisbane providing violence response and legal assistance for people with disabilities; specific examples of good practice by police and in some aspects of the justice system which were particularly responsive and effective for women with disabilities affected by violence.

Women from both jurisdictions identified a range of issues as needing further attention from governments. Commonly identified was the need for better integration of domestic violence and disability services, a lack of accessible violence response services; a lack of representation of the needs of women with disabilities on violence prevention and response agendas; lack of meaningful data collection around violence and women with disabilities; unmet needs of Indigenous women with disabilities; lack of understanding of the needs of children with parents who have disabilities, and often unhelpful responses from the police.

In addition the women in Queensland identified a further range of issues to be addressed that included better recognition of the 'credibility' of women with disabilities, especially in the law, the lack of violence response skills in disability services, and the need for States and Territories to develop and legislate on an agreed definition of domestic/family violence before a national strategy or solution is achieved. It is notable that the Queensland forum generated problematic issues such as more universal recognition, definitions and responses to violence that are similar to the objectives that the women from Victoria recognised as achievements in their state. The presence of a recurrently funded, resourced and recognised organisation of women with disabilities with the standing and credibility to advocate for issues of violence against women and provide a resource for other organisations to consult and utilise in their own sectors and



practices in addressing these issues is perhaps a significant difference between the outcomes and observations of the two forums.

Particularly notable here is that the issues identified as emerging from the forums with women with disabilities align closely with those identified through the findings emerging from the national survey. Broadly these are conceptualised as:

- having informed and commonly shared understandings of violence in the lives of women with disabilities;
- agencies having the capacity to effectively respond to the presence of violence in its various forms and contexts;
- arming the various relevant workforce groups with adequate and relevant skills in responding to and supporting women and girls with disabilities; and
- the need for women with disabilities to be integral to the process of planning, designing and evaluating policy and service measures and strategies to prevent and address violence against women and girls with disabilities.

### 3.3 NATIONAL SURVEY

Through an online survey conducted during April and May 2013, stakeholders in all jurisdictions and across the disability, violence, human service and justice sectors shared their knowledge and experiences, answering questions about the work they do, the policies and legislative frameworks that guide their work, and the challenges they face responding to the needs of women and girls with disabilities experiencing or at risk of violence. The survey targeted the following three stakeholder groups:

- Service Providers - organisations involved in direct service delivery to individual clients including individual advocacy;

- Policy Makers - government and non-government agencies who contribute to the planning, evaluation and/or funding of programs and services; and
- Representative Organisations - organisations that represent the interest of particular groups (such as, people with disabilities, women, people from culturally and linguistically diverse backgrounds) or service providers in a particular sector.

The invitation to participate (and to further distribute the survey through organisational networks) was distributed widely via email to over 460 stakeholder organisations mapped with the assistance of the PSG and the ECG members. A link to the survey and the project webpage was made available on appropriate websites and newsletters to assist with recruitment. PSG members and other project networks were utilised to target any stakeholders, sectors or jurisdictions which appeared to be under-represented in the sample as the survey progressed.

All data collected is in de-identified form and has been analysed by a team of researchers at UNSW. Descriptive and comparative statistical analysis utilising standardised computer software (SPSS) has been undertaken on the quantitative data while qualitative data gathered through open ended survey questions has been compiled and thematically coded in order to draw out common issues identified by respondents. A description of the survey respondents including their sector, size, location, and primary activities in relation to women and girls with disabilities who are experiencing or are at risk of experiencing violence is set out in the remainder of Section 3 below. Key issues emerging from the synthesis of the survey findings, consultations with women with disabilities, research literature and legislative and policy mapping are considered in Section 4.

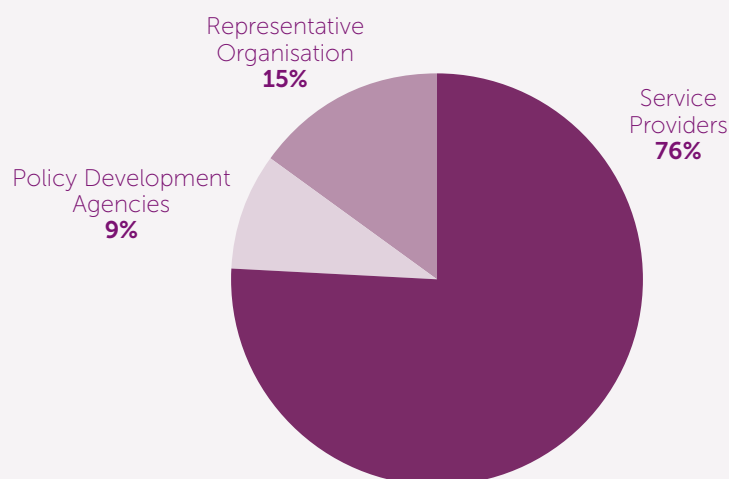
### 3.3.1 SURVEY RESPONDENTS

A total of 367 responses were obtained through the survey. As Figure 1 shows, over three quarters of respondent organisations (279) were involved in direct service provision, 34 in policy development and 54 in representative or advocacy work. This distribution appears reflective of the proportions of stakeholder organisational types across the field. The high rate of participation in the survey is suggestive that violence against women and girls with

disabilities is recognised in the field as a significant issue warranting attention.

All States and Territories are represented in the survey, as well as organisations that operate federally. There is also representation of organisations operating in urban, regional and remote locations, as outlined in Table 1. Note that agencies may operate within more than one jurisdiction and across urban, regional and/or remote areas.

**Figure 1** Stakeholder group representation



**Table 1** Respondent jurisdiction and locational category

Locational Category	National	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Multiple states	Total
Urban	2	45	14	4	12	11	3	6	8	2	107
Urban, regional & remote	13	23	10	6	5	6	14	5	1	6	89
Regional	3	36	8	9	11	3	6	2	1	1	80
Urban & Regional	2	15	6	3	2	0	1	1	4	1	35
Regional & Remote	0	6	2	0	2	1	0	3	0	0	14
Remote	1	4	1	0	0	0	4	1	0	0	11
Skipped question											31
<b>Total</b>	<b>21</b>	<b>129</b>	<b>41</b>	<b>22</b>	<b>32</b>	<b>21</b>	<b>28</b>	<b>18</b>	<b>14</b>	<b>10</b>	<b>367</b>

### 3.3.2 SNAPSHOT OF SERVICE PROVIDER RESPONDENTS

The sample captures a significant proportion of Australia's human services/welfare sector. Table 2 sets out the distribution of service provider respondents across the entire sector. Note that the majority of service providers operate

across multiple sectors. With 122 domestic violence and sexual assault service providers and 102 disability service providers, the sample approaches saturation of these two populations. Other human service sectors such as housing/homelessness (48), health (57) and mental health (40), youth welfare (36) and family and relationship services (35) are also represented.

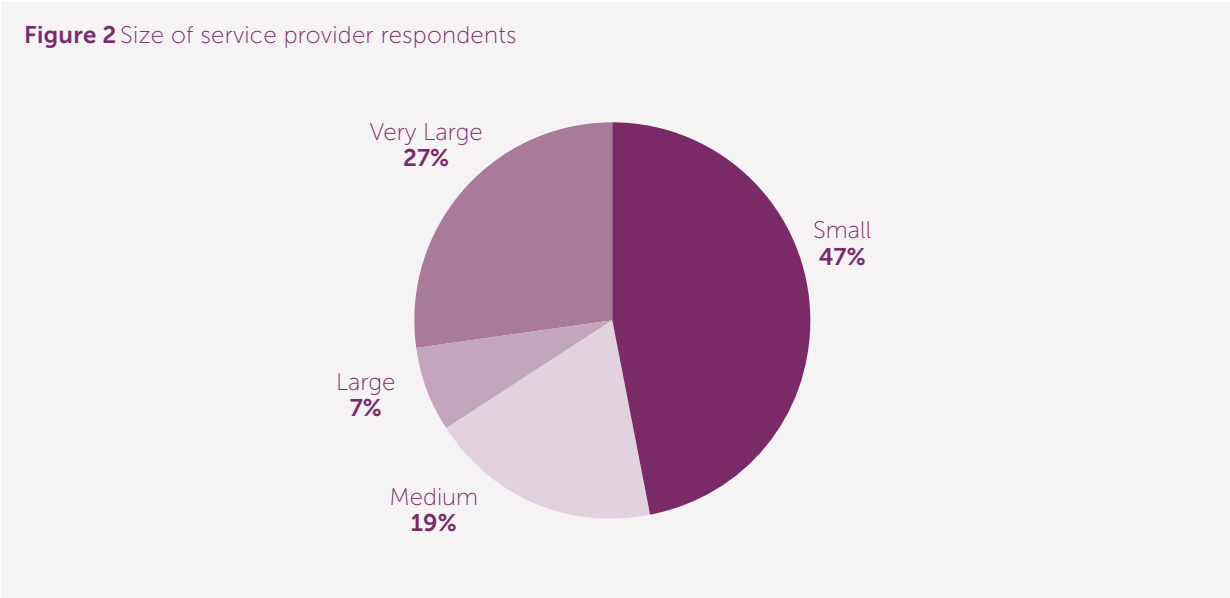
**Table 2** Service providers across service sectors

Sectors	Number of service providers
Domestic violence and sexual assault	122
Disability services (other than employment or mental health)	102
Other health services	57
Housing/homelessness services	48
Information, advice and referral services	42
mental health services	40
Youth services and youth welfare services	36
Family and relationship services	35
Legal services	33
Child welfare, child services and day care	32
Aboriginal and Torres Strait Islander support services	30
Employment/training services	23
Other	16
Services for the aged and elderly (other than residential)	14
Migrant, refugee and asylum seeker services	11
Individual Advocacy	8
Residential aged care and nursing homes	6
Police, correctional, investigation & prosecution	5
Victim support	3

Service providers varied in size, with the majority of responses coming from either small (47%) or very large (27%) organisations. Medium (50) and large (18) service providers together constituted just over a quarter of the overall sample of providers, as indicated in Figure 2.

Of the 165 providers who identified their service as addressing one or more specific client groups, the highest proportion (14%) offered services to people with disability, followed

by women (9%), victims of crime (3%), and people with mental illness (3%). There is also representation of services for Indigenous Australians (5), youth (3), children (3), and people with CALD backgrounds (3). Almost a third or 70 providers direct their services at more than one of these client groups, and over a third (96) do not target their services to any particular group. This suggests that clients have multiple overlapping and intersecting identity 'markers', which collectively bear on the issues for which clients seek services.



As Table 3 indicates, all the respondents who provided information on their services (231) indicated that they provide more than one type of service, with 80 per cent identifying three or more services operating out of their organisation. Of these, 75 per cent engage in individual advocacy, 60 per cent are involved in individual case management, community access, and information, advice and referral

respectively, 60 per cent work in violence prevention, and 57 per cent provide counselling and mental health services. Intervention services such as outreach (55%), court support (52%), in-home support (40%), safe-at-home services (36%) and crisis accommodation (36%) account for a significantly smaller proportion of respondents, suggesting that overall service capacity in these areas is limited.

**Table 3** Areas of service provision

Areas of Service Provision	Number of service providers	Percentage (%)
Individual Advocacy	210	75
Individual case management	171	60
Information, advice & referral	171	61
Community access	171	61
Violence prevention	169	60
Counselling & mental health	158	57
Outreach (phone & online) services	153	55
Court support	145	52
Government lobbying	136	49
In-home support	112	40
Safe-at-home services	101	36
Crisis accommodation	100	36
Medical	89	32
Out-of-home respite	73	26
Legal Aid	72	26
Employment services	69	25
Long-term residential care	67	24
Homeless Shelter	64	23
<b>Total</b>	<b>279</b>	

### 3.3.3 SNAPSHOT OF POLICY DEVELOPMENT AGENCY RESPONDENTS

Thirty-four policy development agencies responded to the survey. At least one organisation from each State and Territory operating in urban, regional and remote areas contributed with the exception of the ACT.

Policy makers responding to the survey are drawn from both the government (23) and non-government (7) sectors, and include a diverse range of portfolio areas. The highest proportions of respondents are from the violence (17) and disability (10) sectors respectively. The remainder of respondents, although limited in number, span the range of human services shown in Table 4. Note that the majority of policy development agencies operate across a range of sectors.

The majority (62%) of respondents are not responsible for funding services. For the twelve that are, four allocate funds specifically for women and girls with disabilities, and eight allocate funds specifically for women and girls experiencing or at risk of violence.

### 3.3.4 SNAPSHOT OF REPRESENTATIVE ORGANISATION RESPONDENTS

Fifty-four representative organisations responded to the survey. Of those who indicated their jurisdiction, six operate at the Federal level and at least one representative organisation from all States and Territories has contributed. Most agencies operate within more than one jurisdiction and across urban, regional and/or remote areas.

**Table 4** Sectoral Spread of Policy Development Agencies

Sector	Number of policy development agencies	Percentage (%)
Domestic Violence and Sexual Assault	17	53
Disability	10	31
Child welfare	7	21
Information and referral	7	21
Youth services	6	18
Family and relationship services	6	18
Mental Health	5	15
Health	5	15
Legal services	5	15
Aboriginal and Torres Strait Islander services	5	15
Employment/training	4	12
Housing/Homelessness	4	12
Migrant, refugee and asylum seeker services	4	12
Services for the aged and elderly (other than residential)	4	12
Residential aged care and nursing homes	2	6
Other	2	6
Victims support	1	3
Police, correctional, investigation and prosecution	1	3



Representative organisations are distributed across the disability sector (18), the violence sector generally (9) and a range of other operational areas (27), including health, human rights, carer organisations and legal services. Representative organisations responding to the survey vary in size, with half of respondents being small agencies (up to 20 staff), almost one third (32%) being very large organisations (200+ staff), and the remainder either medium (up to 100 staff) (16%) or large (up to 200 staff) (2%).

In terms of their constituencies, 20 per cent of respondents (10) represent service providers, while 68 per cent (34) represent the interests of particular groups, with several representing multiple groups. Table 5 shows the diversity of representation. Seventy per cent of organisations

represent people with disability, almost two thirds represent women, almost one third represent both children and those who are homeless, 20 per cent represent both youth and Aboriginal and Torres Strait Islander people, and one organisation represents the interests of carers.

The majority of representative organisations in the survey receive their funding from governments, with those funded by their respective State and Territory government (33%) outweighing those receiving Commonwealth funding (16%). A further three organisations received their funding from private contributions, one from local government, and ten from multiple sources.

**Table 5** Representative organisation target group

	Number	Percentage %
Women	19	63
People with disability	21	70
Homeless	9	30
Youth	6	20
Aboriginal and Torres Strait Islander	6	20
Children	9	30
Culturally and linguistically diverse communities	8	26
Other	1	3

As part of their representative work, these organisations are involved in a diverse range of engagement, with many indicating that they undertake multiple representational activities. Most commonly agencies undertake public education and awareness activities (73%), advocacy for policy change (66%) and input into policy development (61%). Consulting (50%), staff training and capacity building (47%), sector development (45%), research (42%) and

media campaigning (38%) are also commonly undertaken. As Table 6 indicates, half of the respondents (21) are also involved in direct service provision. The interests of women and girls experiencing or at risk of violence are encompassed within, although not necessarily the main focus of, the advocacy work of 81 per cent of the representative organisations responding to the survey.

**Table 6** Activities undertaken by Representative Organisations

Representational Activities	Responses	Percentage (%)
Public education & awareness	31	73
Advocacy for policy change	28	66
Input into policy development	26	61
Consulting & Advising	21	50
Direct service provision	21	50
Staff training & capacity building	20	47
Sector development	19	45
Research	18	42
Media campaigning	16	38
Other	5	11



## 4 KEY EMERGING ISSUES

### INTRODUCTION AND OVERVIEW

A synthesis of the survey findings, consultations with women with disabilities, research literature and legislative and policy mapping undertaken for the STVP suggest six key thematic areas currently presenting challenges to the provision of accessible and responsive services for women and girls with disabilities who are experiencing or at risk of violence. These areas encompass cultural, social, structural and practical issues and barriers that currently characterise the field and are identified as:

#### **THEME 1** RECOGNISING VIOLENCE

This theme explores the prevalence of violence against women and girls with disabilities, patterns of service usage by such women, and the capacity of service providers to identify, record and respond to violence in its various forms and contexts.

#### **THEME 2** RESPONDING TO VIOLENCE

This theme explores the capacity of service providers to respond to overt and covert forms of violence against women with disabilities, the barriers that prevent such women from accessing appropriate services, and ways of removing these barriers through better policy and practice measures.

#### **THEME 3** INCLUSION AND PARTICIPATION

This theme explores participatory and inclusive decision making within service and policy environments and ways to support the participation of women with disabilities in representation, information sharing, service planning and policy development.

#### **THEME 4** SECTOR DEVELOPMENT

This theme explores the structural issues contributing to the under-servicing of women and girls with disabilities experiencing or at risk of violence, and canvasses ways to develop the service sector through appropriate service guidelines, regulatory frameworks, staff training, and skills sharing programs.

## THEME 5 CROSS-SECTOR COLLABORATION

This theme explores the nature and extent of inter-agency and cross-sector collaboration between all three stakeholder groups: service providers, policy development agencies and representative groups. It also identifies the need for a clearer and more structured framework for cross-sector collaboration to provide pathways to safety and support for women and girls with disabilities experiencing or at risk of violence.

## THEME 6 DATA CAPTURE AND USE

This theme explores the ways that data on women and girls with disabilities experiencing or at risk of violence are currently collected, transmitted and used by stakeholder groups. It highlights the need for a more strategic approach to collecting this type of data to inform service policy, planning and delivery on the issue of violence against women and girls with disabilities.

For each of the above six thematic areas this section sets out detailed information related to the following key areas.

- Context of the issue
- Evidence emerging from stakeholder consultations, survey and other information gathering activities
- Implications

The additional STVP document *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Discussion Paper* summarises this material and in addition identifies **Key Areas for Reform**.

## THEME 1 RECOGNISING VIOLENCE

### 1.1 CONTEXT

In order to address violence against women and girls with disabilities a key foundational capacity includes the ability to recognise the presence of violence in an individual's life. Acknowledgement that violence is occurring or is at risk of being perpetrated is required by both the individual experiencing/at risk of violence and those persons, organisations and service providers surrounding the individual. A range of issues may undermine the recognition of violence occurring within the lives of women and girls with disabilities, such as:

- women and girls with disabilities may not themselves be aware and recognise their own experiences as domestic and sexual violence. Community education regarding violence may not be accessible or applicable to women with disability;
- the difficulty accessing spaces where women and girls with disabilities may safely disclose such violence;
- the availability of appropriate supports, such as interpreters and other personal supports to assist this disclosure; and
- having a trusted individual to whom disclosure of violence can be made and taken seriously.

The survey sought information from service providers, policy makers and representative organisations to ascertain the capacity of organisations to effectively recognise when violence is occurring. Information was sought regarding service usage by women and girls with disabilities in order to establish that this pool of respondents in fact saw women and girls with disabilities as part of their service group and therefore could reasonably be

expected to have addressed the issue of recognition of violence in their service users. The survey also explored whether and how violence is perceived and identified by services and whether, once recognised, it is recorded in any systematic manner. Service providers were also asked to report the incidence and nature of any violence their service users had disclosed within the past year.

## 1.2 EVIDENCE

### 1.2.1 PROFILE OF SERVICE USERS

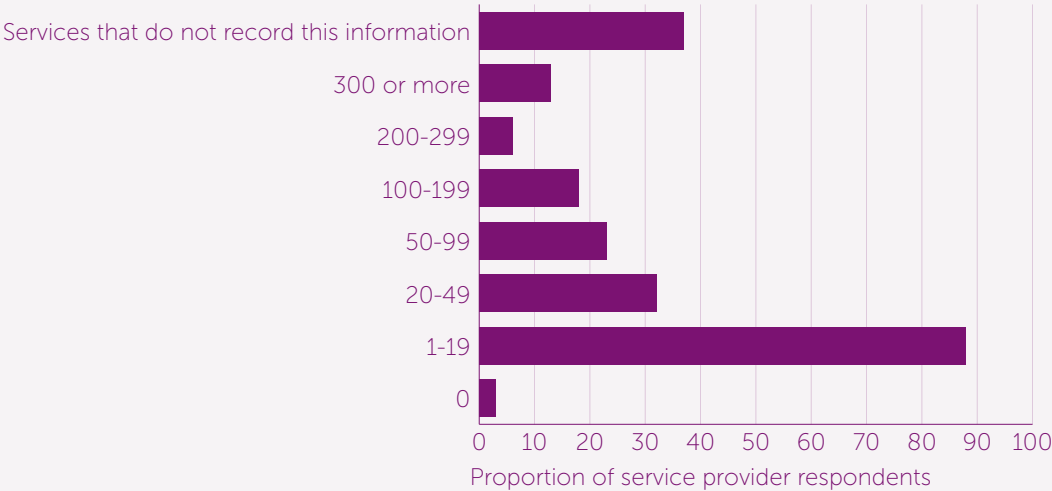
Of the total of 279 service provider respondents, 223 provided information about their client base. Of these 223 service providers, 183 reported that women with disabilities access their services. Notably, sixteen per cent or 37 service providers do not record the presence of disability at all when collecting client information. While levels of service usage by women with disabilities vary, as Figure 3 indicates, 56 per cent of respondents have provided up to 100 women with disabilities with a service in the past year. Almost 10 per cent or 18 service providers identified up to 200

women with disabilities as current or previous clients, six identified up to 300, and fourteen identified more than 300. Since large numbers of women with disabilities access these services, the respondents were well placed to provide accurate and meaningful information about the challenges associated with recognising and meeting the service needs of this group.

### 1.2.2 INCIDENCE OF VIOLENCE

In order to establish a picture of the recognition of the presence of violence in the lives of those women and girls with disabilities who currently access services, respondents were asked whether they recorded whether women and girls with disabilities utilising their services had experienced violence in the past year. Of the 279 service provider respondents, 71 did not provide a response to this question and a further 37 services indicated that they do not attempt to record whether women and girls with disabilities presenting at their service have experienced violence in the past year. This means that 128 services were not able to report on their recognition of violence in the lives of their female clients with disabilities. Of the 151 services who did attempt some identification

**Figure 3** Number of WGWD having accessed human services in the past year



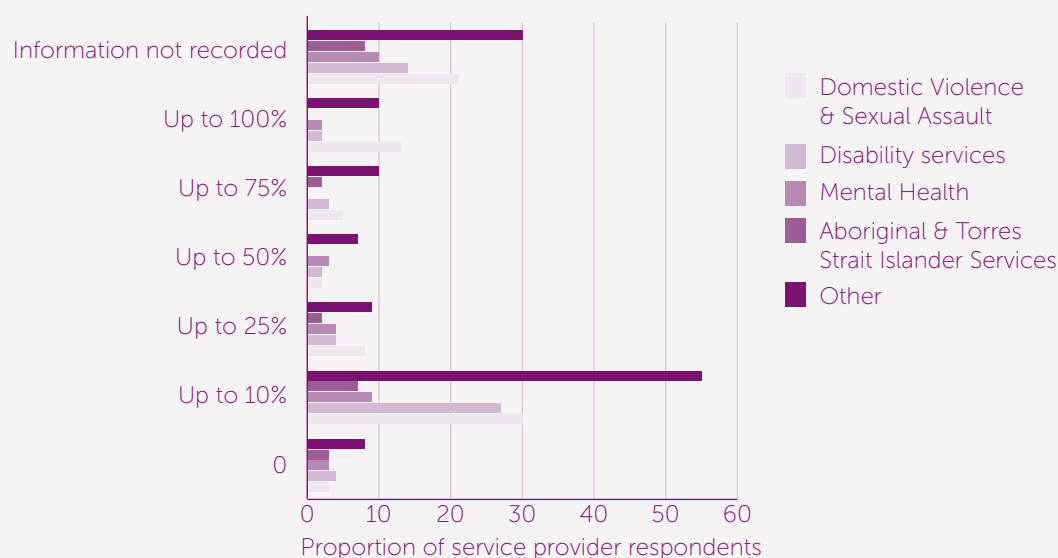
or recognition of the presence of violence in the lives of women and girl clients with disabilities, 92 per cent of a total of 139 services identified that women and girls accessing their services had experienced violence in the previous year.

A significant proportion of service provider respondents who attempted to recognise and record the presence of violence in the lives of their service users indicated generally high proportions of women and girls with disabilities presenting at their service having experienced violence in the past year. Twelve per cent of these services had recorded violence in the lives of up to 100 per cent of their female clients with disabilities. Eight per cent of services recorded a rate of up to 75 per cent, and 5 per cent of services a rate of up to 50 per cent. A total of 85 service providers or 56 per cent of respondents had identified violence in up to 10 per cent of their female disabled client base. Only eight per cent or 12 service providers had not had a

woman or girl with a disability present at their service having experienced violence in the past year.

A conservative aggregation of these rates shows that violence is present in the lives of approximately 22 per cent of women and girls with disabilities who, within the past year, have made contact with service provider respondents to this survey. Given the survey's high response rate, this figure likely reflects the prevalence of violence against women and girls with disabilities who are or have recently been in contact with service providers across the whole of Australia. While it is recognised that the type of service provided will determine the likelihood that clients will have experienced violence and therefore influence the likelihood of recognition, survey findings as set out in Figure 4 show that recognition occurs in varying patterns and rates across different service sectors.

**Figure 4** Percentage of women service users with disabilities recorded by service providers as having experienced violence in the past year





Of the 80 service provider respondents from the domestic violence and sexual assault sectors, 21 respondents or more than a quarter did not collect information on whether their women and girls with disabilities service users had experienced violence in the past year. Of the 56 services that did identify such experiences in their women clients with disabilities, 55 per cent or 39 services identified violence in up to 50 per cent of their female clients with disabilities. A further 21 per cent of respondents identified and recorded violence in the lives of 50 to 100 per cent of their female clients with disabilities.

For the 52 disability service providers who provided information about their recognition and identification of violence in the lives of their female service users, 27 per cent or 14 services do not record any information about the presence of violence for their clients with disability. Of the 38 services who do record such information, 89 per cent or 34 services had recognised and recorded the presence of violence against women and girls with disabilities within the past year, and 57 of these had recorded violence in the lives of up to 25 per cent of their female clients with disabilities.

Counselling and mental health services reported particularly poor recording rates, with over a third (37%) of the 10 respondents of these services lacking any mechanism with which to record the occurrence of violence against female service users with disabilities. Of the 17 mental health services that did record such information, over half or 14 services had identified violence in the lives of between 1 and 50 per cent of their female clients with disabilities. For one mental health service, up to 100 of women clients with disabilities had experienced violence in the year prior. That the overwhelming majority (88%) of the 15 mental health services providers with the capacity to identify and record violence had done so within the past year suggests that the mental health sector is where many women with disabilities first enter and seek help within the service system once violence has occurred.

Of the 17 Aboriginal and Torres Strait Islander services that provided information about their recognition and identification of violence in the lives of their female service users, almost half or 8 service providers identified and recorded violence against women and girls with disabilities as an issue facing its client base. Seven of the 17 Aboriginal and Torres Strait Islander services, however, do not keep records of whether or not violence is present in the lives of their women clients with a disability. Other services – including those from the housing/homelessness sector, the youth services sector, child welfare, employment and training, health, aged care and the justice sector – had recorded similarly high rates of violence amongst their female clients with disabilities. Of these, a further 129 other services, 23 per cent or 30 services do not seek to record whether violence is present or not in the lives of their female clients with disabilities. Of the 99 services that do identify and record such information, 91 services (91%) have done so in the past year.

These findings very likely under-represent the prevalence of violence against women with disabilities, given that ten per cent of service provider respondents do not record this information, and that many victims of violence do not, are unable to, or are prevented from disclosing the frequency or type of violence perpetrated against them. This is especially true for women and girls with disabilities, as the presence of disability often means the victim is particularly dependent on or emotionally attached to the perpetrator, making it difficult and/or dangerous for her to seek support, communicate effectively, and initiate a pathway to safety. This problem is likely to be especially acute for children and younger women, given their level of dependence on family members and carers who may be the perpetrators of violence towards them. The evidence presented here indicates that violence against women and girls with disabilities is a significant issue within all human service sectors. While some services have the capacity to identify and record the presence of violence but not necessarily to address or prevent it, a significant proportion of services do not record this information at all.

### 1.2.3 TYPES OF VIOLENCE

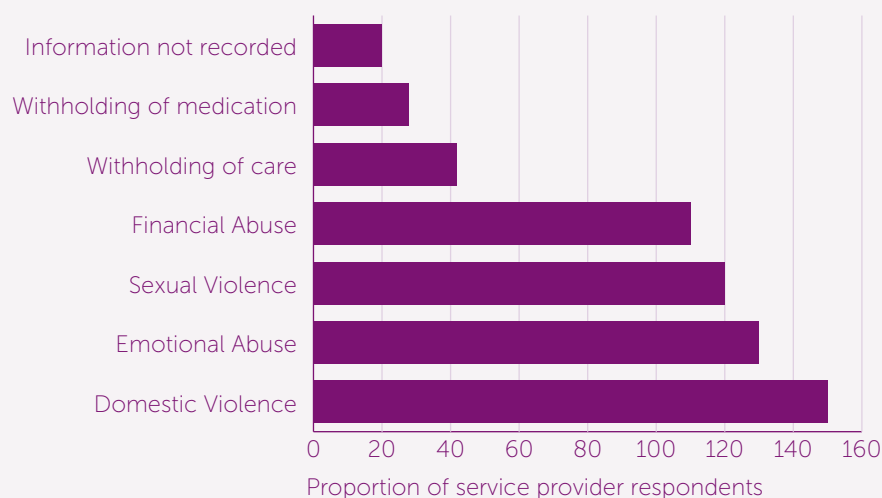
Services who take steps to recognise and identify the presence of violence were also asked about the types of violence most often disclosed by women and girls with disabilities who use their service. The incidence of the various types of violence as disclosed by these women and girls is set out in Figure 5.

Of the 191 service providers who responded to this question, 171 or 90 per cent record information about the type/s of violence perpetrated against women and girls with disabilities. Of the 20 service providers that do not record information at this level of detail, seven are from the disability sector and five are from the domestic violence and sexual assault sectors. Many service providers recorded multiple types of violence experienced by their female clients with disabilities. Eighty per cent or 151 of service providers identified their women clients with disabilities as having experienced domestic violence. Sixty-eight per cent or 130 recorded the presence of emotional abuse

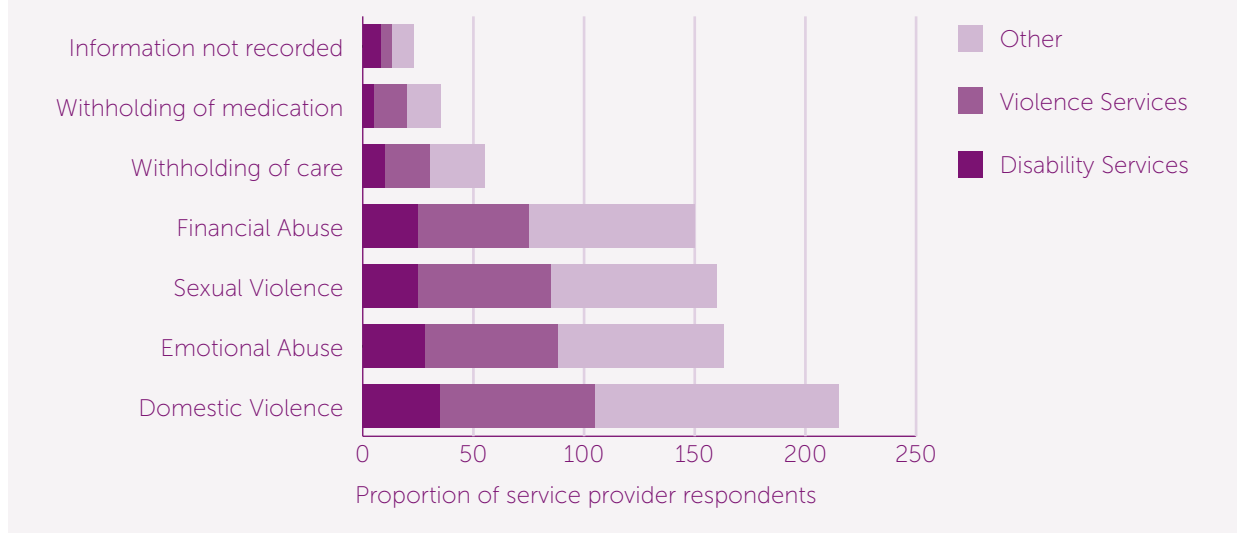
in the lives of their female service users with disability, 63 per cent or 120 recorded the presence of sexual abuse, 109 or 58 per cent recorded the presence of financial abuse, 23 per cent or 43 recorded the withholding of care, and fourteen per cent or 26 recorded the withholding of medication.

Violence services record more information about the types of violence perpetrated against women and girls with disabilities than disability services, as shown in Figure 6. This applies even with regards to disability-related violence such as the withholding of care and the withholding of medication. More detailed analysis of the types of violence recorded suggests that the amount and nature of information recorded by service providers varies between sectors. As might be expected, a relatively small minority (7%) or five of violence services fail to record the type of violence experienced by their female clients with disabilities. Of concern, however, is that sixteen per cent or seven disability services do not record this information.

**Figure 5** Types of violence recorded by service providers



**Figure 6** Types of Violence Recorded by Service Providers



Thirty two per cent (22) of violence services and 23 per cent (27) of other services have recorded care being withheld from their women clients with disabilities. Nineteen per cent (28) of disability services have identified this form of violence in their female client base. While 24 per cent of violence services (16) and thirteen per cent (15) of other services have recorded medication being withheld, only 11 per cent (5) of disability services have identified this as occurring in their female client group. Of concern is that eight per cent (12) of disability services make no attempt to record the type/s of violence experienced by their female clients.

#### 1.2.4 SUPPORTING IDENTIFICATION AND DISCLOSURE

Service providers were asked to identify barriers, challenges and opportunities for increasing their capacity for recognising and identifying violence in the lives of women and girls with disabilities who may access their service. Several key concerns emerged. Firstly, as noted earlier, the need for women and girls with disabilities themselves to be aware of their rights and to be able to recognise and name violence occurring in their lives was commonly identified. Corollary to this is the need for all services to address

women and girls with disabilities without discrimination and with full respect for their human rights. As important as unrecognised or undisclosed violence were issues of unrecognised or undisclosed disability.

Service providers identified the need for the development of capacity within services to build relationships with women and girls with disabilities in order to create trusting and responsive environments within which such women and girls would feel safe and encouraged to report incidences of violence. Service specific measures identified by service providers included both contextual and procedural matters.

Contextually, explicit recognition of the issue by service providers operating in this space included the following areas:

- acknowledgement that women and girls with disabilities were at heightened risk of violence;
- awareness that there was a high prevalence of violence among this population group; and therefore, generally required greater orientation and sensitisation to the possibility of violence occurring in the lives of their female service users with disabilities.

Moreover, other contextual factors also include community and social attitudes to violence against women and girls with disabilities. Service providers reported their perception that community attitudes largely normalises the potential risk and experience of violence among some families. Some service providers highlighted the issue of the definition of domestic violence not including violence by carers. Others indicated that as the issue of violence against women and girls with disabilities is not recognised as a core service delivery area by service providers in the violence sector, the true extent of the problem is very likely to be unrecognised. Leadership by organisational management personnel in bringing these issues to light as important in the service and beyond to policy makers was identified as a key process that can enhance awareness and recognition of violence and its impact on women and girls with disabilities.

Procedurally, having staff with the appropriate skills in recognising and understanding both disability and violence was identified as a challenge, including working with people with various types of disabilities and understanding their access and support needs. Some services indicated that they had addressed this by developing a list of indicators of both disability and violence to support their staff to be aware of, identify and respond to possible issues which may arise and are reported on as well as monitored and collated. Very specifically the lack of safe reporting opportunities was identified, including issues such as the carer/perpetrator attending appointments and difficulties in disclosure of violence by children with disabilities who may be in a similar situation.

Policy makers who provided information to the survey indicated awareness of many of these same issues as identified by service providers. Their observations included that many victims of domestic and family violence are reluctant to report the violence to police. Victims under report violence due to factors such as shame, fear, age, lack of support if disclosed and impact

of cultural factors that justify violent behaviour. This is compounded in many cases whereby a woman with disabilities is unaware that she has rights, that there are laws to protect her, or that the behaviour is abusive; when she lacks access to appropriate information; and has had previous negative experiences with police (particularly in cases involving women with psychosocial disability). In addition, community stigma can be entrenched in service provision and workers may sometimes not trust the victim to give an honest or accurate description in order to protect the family unit. In addition, some women and girls with disabilities lack knowledge on what to do if they are exposed to violence. Importantly policy makers highlighted that these issues are often brought to their attention by representative groups, peak bodies and advocacy agencies.

Representative organisations were particularly concerned at the lack of awareness by service providers and the community in general that women and girls with disabilities are victims of domestic violence and abuse. They feel that disability often overshadows issues of violence and some services found it 'too hard' to deal with clients who had cognitive disabilities. They observed that many women and girls with disabilities do not access services because they fear victimisation and stigma and sometimes because their past experiences of violence had not been recognised. Additionally, some representative organisations highlighted that often women and girls with disabilities lack information about domestic violence and abuse, and being dependent on others for daily support make it difficult for them to access support services.

Challenges facing advocacy work carried out by representative organisations in relation to gender, disability, violence were observed to be hampered by a lack of commitment to international human rights treaty obligations in government legislation and policy with human rights treaties not being integrated into domestic laws or because organisations were not educated to respond to challenges through a

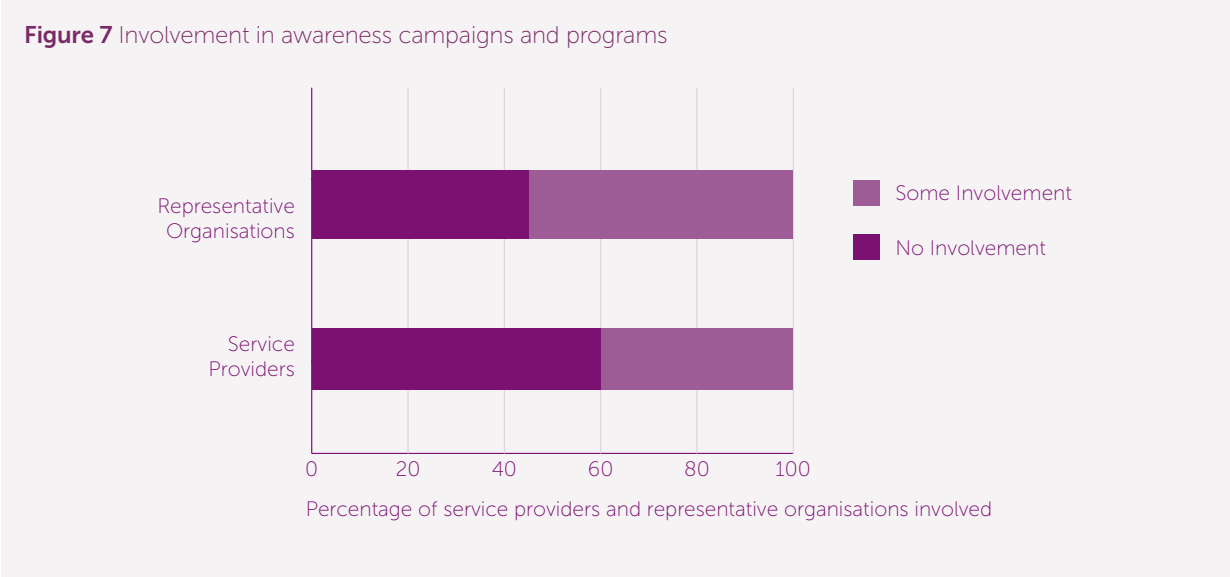
human rights framework. They suggest the need to develop comprehensive national, uniform, human rights based legislation and policy which explicitly recognises the impact of multiple discriminations caused by the intersection of gender and disability and the use of a gendered approach in National Disability Insurance Scheme.

### 1.2.5 AWARENESS AND PREVENTION OF VIOLENCE

In the area of awareness and prevention of violence, there were different levels of engagement across the three different stakeholder groups. Overall, service providers were the least engaged with awareness and prevention strategies and representative groups the most engaged, with policy officials sitting between these two positions. A key finding

of concern in the survey responses is that the majority (106) or 76 per cent of service providers reported no involvement in any public or community oriented campaigns or programs aimed at preventing violence against women with disabilities.

Of the 34 service provider organisations that were engaged in some type of prevention work, only six were disability services. Of the 106 that did not, 20 per cent had identified violence in the lives of their female clients with disabilities within the past year, and over a quarter did not record this information. Service providers also showed a relatively low level of involvement in awareness campaigns (39%). Just over half or 14 representative organisations respondents reported some level of involvement in campaigns and programs aimed at raising awareness around the issue of violence against women and girls with disabilities, as shown in Figure 7.



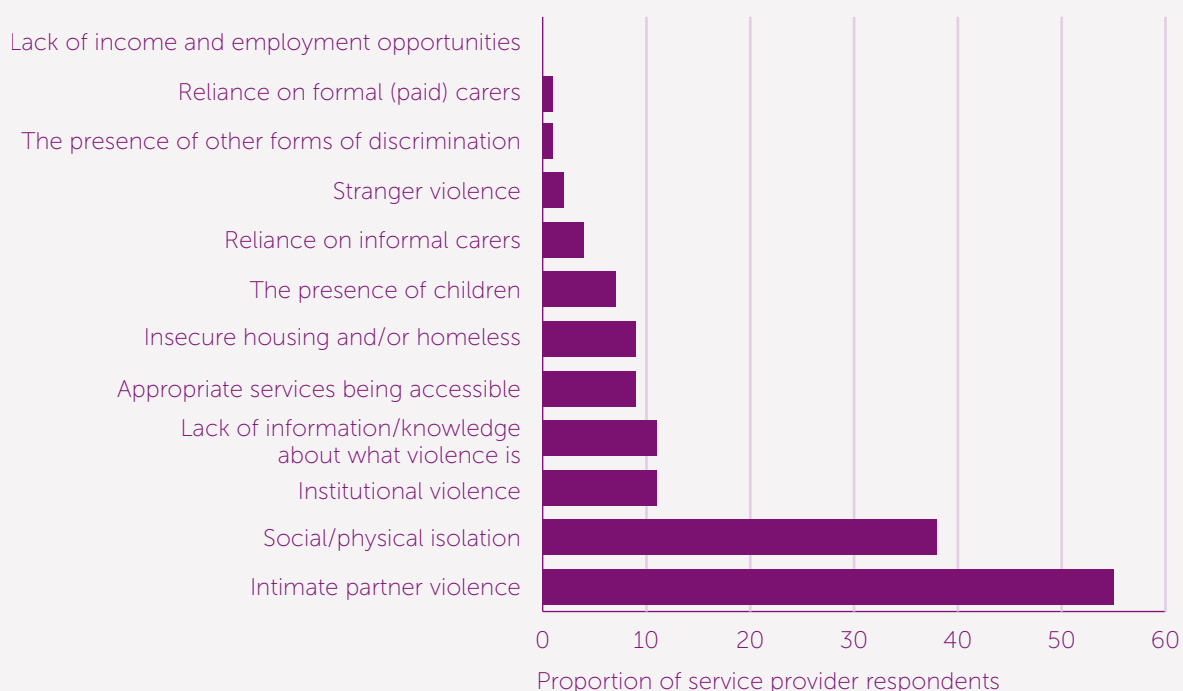
Service providers were also asked to rate the perceived importance of particular issues facing women and girls with disabilities experiencing or at risk of violence. As Figure 8 shows, the issues rated of most concern to respondents were intimate partner violence and social/physical isolation. Issues such as institutional violence (i.e., violence in institutional settings including residential care facilities, respite centres, etc.), lack of information/knowledge about what constitutes violence, including disability-specific forms of violence experienced by this group, inaccessibility of services, insecure housing and the presence of children were also ranked as important issues facing women with disabilities experiencing or at risk of violence.

All respondents to the survey stated that greater community awareness on issues of violence against women and girls with disabilities through community/public forums as well as promotion of available services was necessary to increase

awareness of the issue and, also to promote the prevention of violence for this group. All respondent groups, including public policy officials responding to the survey, reported that more resources were needed to carry out community awareness programs for prevention of violence, especially early intervention programs targeted at girls with disabilities.

Interestingly, service providers reported a general lack of awareness on the issue on their own part. Several services identified that responding to the survey was itself the first time that they had become aware of the issue, while others indicated that thinking through their responses to the survey had revealed the need for changes to be made to their organisational policies. By way of contrast one exemplary agency indicated that all workers within the service 'have awareness of violence as a possibility and safety plans provide the framework on how to deal with the issue, such as limiting or controlling exposure to suspected perpetrators'.

**Figure 8** Issues facing WGWD experiencing/at risk of violence





Some service providers also identified the need for more awareness and education for women and girls with disabilities to 'empower' them to recognise and disclose violence in their lives. Low self-esteem among women and girls with disabilities was also recognised as an issue. Lack of information on rights, expectations and supports available were another issue identified by service providers. In particular, lack of awareness and understanding of the issue among CALD clients, as well as lack of information and awareness among Indigenous women regarding eligibility for access for disability support were identified.

All respondents agreed that broad media coverage and promoting public awareness to de-stigmatise the issue were important areas for successful campaigns and programs aimed at preventing violence against women and girls with disabilities. Service providers suggested that using a holistic approach, educating carers and targeting specific problem areas would also contribute to the success of campaigns and programs. In some communities, it was felt that the local or kinship leadership needed to be targeted.

Respondents also provided a range of suggested strategies to design effective awareness and prevention strategies for the target group. For example, the use of simple messaging and multiple communication styles was seen as essential for a successful campaign/program. Use of personalised experience was also seen by some service providers as a key element of successful prevention campaigns and programs as was consistency of messaging, the use of evidence-based information and the use of social and multi-media.

Discriminatory attitudes within the broader community and the lack of community awareness on the particular vulnerability of women and girls with disabilities to violence and the need to ensure adequate protection for them in domestic and family violence legislation through the use of a gendered approach have been brought to the attention of policy

makers by representative groups, peak bodies and advocacy agencies. Ensuring mandatory reporting in instances where there is reasonable suspicion of abuse and neglect and the use of accessible information on preventive measures as well as disability specific advocacy on the web were some of the ways that policy makers felt would enable better service responses on issues of violence against women and girls with disabilities. The availability of accessible information regarding services was seen as a key measure to enhance access to services by women and girls with disabilities.

### 1.3 SUMMARY IMPLICATIONS

- Findings from the survey provide data only on women and girls with disabilities who access services. However, current literature and Australian Government reporting on the service use of people with disabilities suggests that many women and girls with disabilities do not use or access services. Given this broader picture of service usage amongst the population of women with disabilities, it is likely that significant numbers of women and girls with disabilities who are experiencing or at risk of violence do not access any type of service. This suggests that the prevalence of violence against women and girls with disabilities is likely to be even higher than the 22 per cent suggested by the current survey findings.
- Addressing violence against women and girls with disabilities is not currently a core service priority for many service provider respondents to the survey. This may have implications for non-responsiveness to violence when disclosed or for failure to respond appropriately to those in need. When responding to violence is outside the organisational mandate and contracted outputs, services do not have the capacity to effectively recognise, and hence respond to, violence. In many instances where violence is identified, the key service response is referral. Referring on does not necessarily guarantee a response

that ensures a *pathway to safety* which in contrast to referral provides service supports to protect the wellbeing of the individual concerned.

- The survey findings strongly suggest that, via their own admission, disability services generally do not have the capacity or expertise to recognise overt forms of violence. This has significant implications also for services capacity to identify 'covert' forms of violence. As noted in the literature, women and girls with disabilities are more likely to experience covert and subtle forms of violence rather than blatant overt violence and abuse. Therefore, if disability services, where much violence prevails against this population group, are unable to readily acknowledge and identify overt violence, it is possible to infer even less capacity to identify subtle, covert and disability specific forms of violence. Thus, the findings suggest that disability services may be unable to meet their legal duty of care obligations, as defined in both the relevant Commonwealth and State/Territory disability services legislation contractual obligations.
- One of the key findings from the survey suggests that practices of withholding medication as a form of violence readily occur and are recognised as such by a number of service providers as a type of violence against women and girls with disabilities. However, from the survey results we are unable to identify if this is a form of 'neglect' or an 'active' perpetration of violence against women

and girls with disabilities who are service users. Using medication as a control mechanism, on the other hand, is recognised as a restrictive practice and an 'active' perpetration of violence. This highlights a problem in how the issue of violence against women with disabilities is represented in public policy in Australia. Some Australian jurisdictions understand and legislate family violence/intimate partner violence in very narrow terms and do not recognise forms of care-related violence. The issue of care-related violence is recognised in the literature on violence against people with disabilities (Sobsey 1994; Fitzsimons 2009) but this literature does not specifically deal with the gendered nature of such violence. Similarly, there is a concern that the active/neglectful withholding of medication has been largely overlooked nationally and internationally as a potential area of violence.

- Findings from the survey suggest that there is poor identification and disclosure of violence against women and girls with disabilities among mental health services. However, it has been reported in the literature that a number of women and girls with disabilities experiencing, or who have experienced violence are likely to utilise mental health services as a result of this violence. This suggests the need for greater understanding, information, screening and reporting of issues specific to violence experienced by women and girls with disabilities in the mental health sector.

## THEME 2 RESPONDING TO VIOLENCE

### 2.1 CONTEXT

It is known that women and girls with disabilities are twice as likely to experience domestic violence and other forms of gender-based and sexual violence as women and girls without disabilities. Their experiences are also likely to last over a longer period of time, and they suffer more severe injuries as a result of the violence. As a result they have high levels of need in terms of service responses as well as requiring interventions that are more complex to ensure appropriate support and safety. Currently there is limited understanding of the ways the multiple systems of service delivery responds to this group. In order to explore the capacity, responsiveness and efficacy of the current service system, respondents to the survey were asked their views about the match between demand and capacity in current services and the ways in which they currently, or would in the future act to address any mismatch.

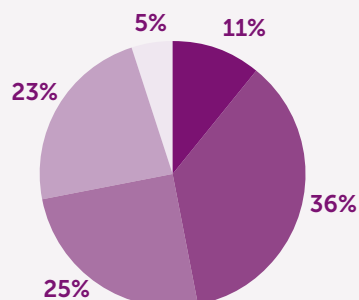
### 2.2 EVIDENCE

#### 2.2.1 SERVICE PROVIDER CAPACITY

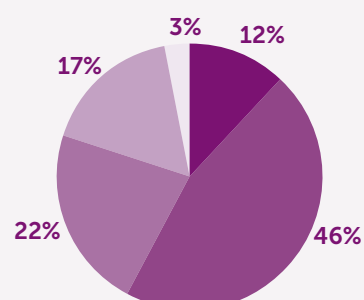
Service providers were asked to identify the capacity of their organisation to meet current levels of demand from women and girls with disabilities experiencing violence. Of the 201 respondents to this question, less than half or 92 service providers agreed that their organisation meets current levels of demand, while a quarter did not have a view either way, as Figure 9 indicates. The fact of such low levels of adequate servicing is of significant concern. Of further concern, 50 organisations noted that their waiting lists were growing, which commonly occurs when demand outstrips the level of available resources, as shown in Figure 14.

Where organisations lack service capacity, this was not attributed to the constraints or pressures of eligibility criteria, as Figure 15 shows. Instead, as Figure 16 shows, the majority (66%) of respondents pointed to the level of available resources as a key factor influencing their service capacity. Over a third or 72 service providers reported that in order to maximise their service capacity they reallocate resources and just under a third (63) stated they target services more tightly (see Figure 12). The majority (111) of organisations emphasised the need for staff training to be able to address the specific needs of women and girls with disabilities experiencing violence, as Figure 10 suggests.

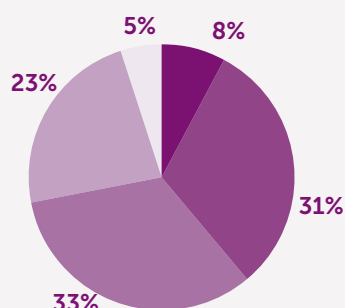
**Figure 9** Organisation meets current demand



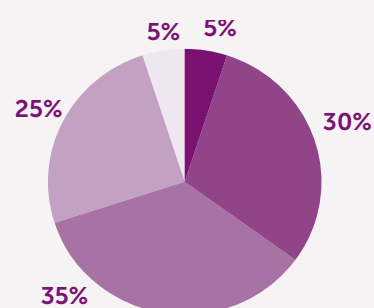
**Figure 10** Staff require more training to meet demand



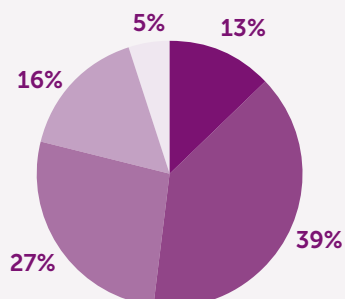
**Figure 11** Organisation reallocates resources to meet demand



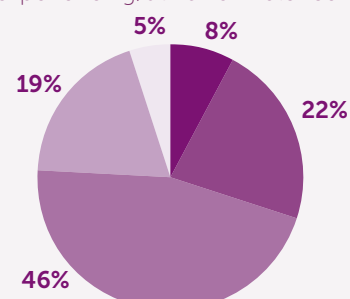
**Figure 12** Organisation targets services more tightly or limit service levels to meet demand



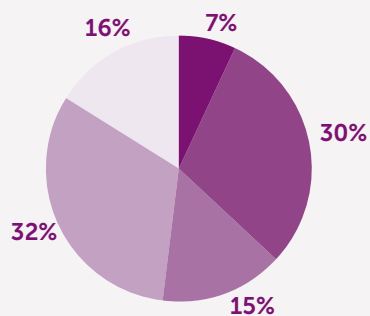
**Figure 13** Organisation is unaware of current level of demand



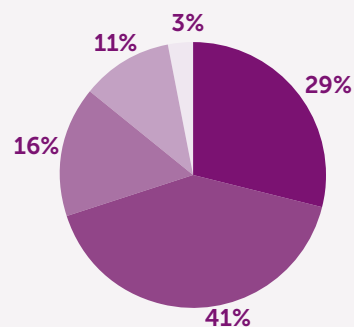
**Figure 14** Waiting lists are growing for WGWD experiencing/at risk of violence



**Figure 15** Service capacity is constrained by eligibility criteria



**Figure 16** Service capacity is constrained by the level of available resources



Strongly agree  
Agree

Neither agree or disagree

Disagree  
Strongly disagree

Considering these issues of under-servicing, also problematic is that the majority (51%) of service providers are unaware of what the level demand is from female victims of violence with disability, as shown in Figure 13. Levels of awareness appear particularly poor in the Aboriginal and Torres Strait Islander support service sector, with half of all Aboriginal and Torres Strait Islander services in agreement over their lack of awareness in this particular area. Fifty-three per cent of disability services and 52 per cent of domestic violence and sexual assault services also agree that they lack knowledge of demand from these women, as do 12 per cent of services from a range of other sectors (see Figure 17).

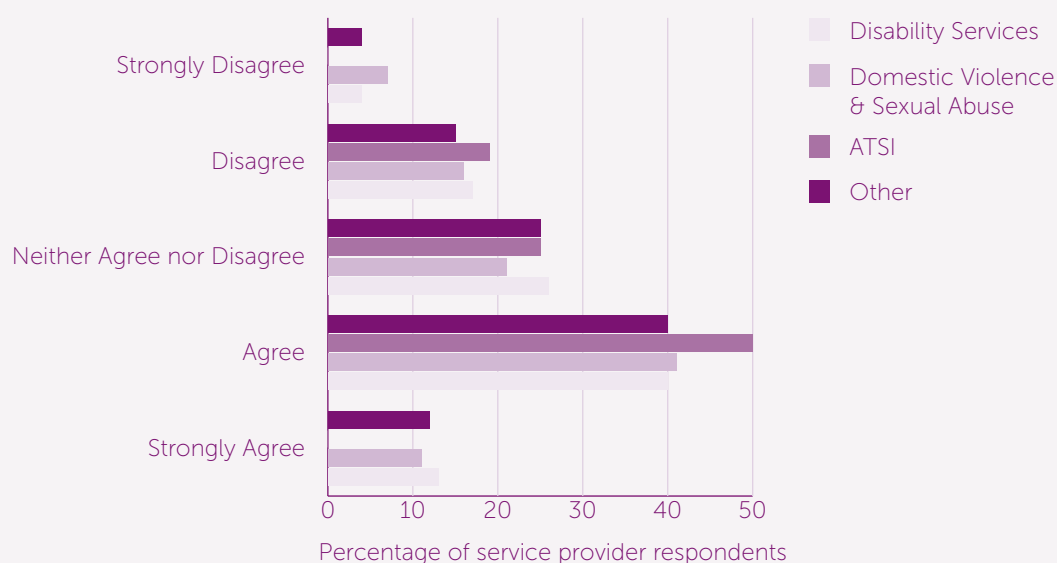
Survey findings suggest that while there is a relatively constant level of unmet need across all service types, there is some variation in the capacity of service providers to meet demand from women and girls with disabilities experiencing or at risk of violence. Managing demand pressures appears particularly

challenging for residential services, with only 43 per cent of long-term residential care services, 41 per cent of respite services, 44 per cent of crisis accommodation services, and 42 per cent of homeless services agreeing that they currently meet demand for services from this group. Over half of all medical (58%), legal aid (57%), court support (53%), outreach (53%), safe-at-home (52%) and counselling and mental health (52%) services agreed that they meet demand from women and girls with disabilities experiencing or at risk of violence, however a number of respondents working in outreach (7%) and mental health (6%) were in strong disagreement.

Some of these services reported that they were already over stretched and lacked the capacity to respond to current levels of demand from women and girls with disabilities experiencing or at risk of violence. Other services were affected by the lack of accessible transport and the need to make structural changes to existing buildings so that they are more accessible for women and girls with disabilities.

**Figure 17** Awareness of demand across sectors

**STATEMENT** ORGANISATION IS UNAWARE OF CURRENT LEVEL OF DEMAND



Regional and remote areas appear underserved and this was particularly felt by service providers in Western Australia and Queensland. Additionally, both South Australia and Queensland suggested that increased funding was required to enable outreach services targeted at women and girls with disabilities.

## 2.2.2 POLICY MAKING FOR SERVICE RESPONSE

Two thirds (8) of policy agency respondents believe that demand from women and girls with disabilities experiencing or at risk of violence is not being met by service providers. More than two thirds of policy agency respondents also indicated that they lack knowledge about the size and nature of this demand at the policy level, indicating a disconnect between knowledge of the problem and policy response. There was strong emphasis placed by policy agency respondents on the need for further staff training in disability and violence awareness, with nine out of twelve respondents agreeing this is a necessary measure. In general, policy agency respondents agreed that service providers respond to demand pressures by reallocating resources and/or more rightly targeting their services. Policy makers on the whole were not clear about whether service capacity is constrained by eligibility criteria but eight out of twelve did agree that service capacity is currently constrained by the level of available resources.

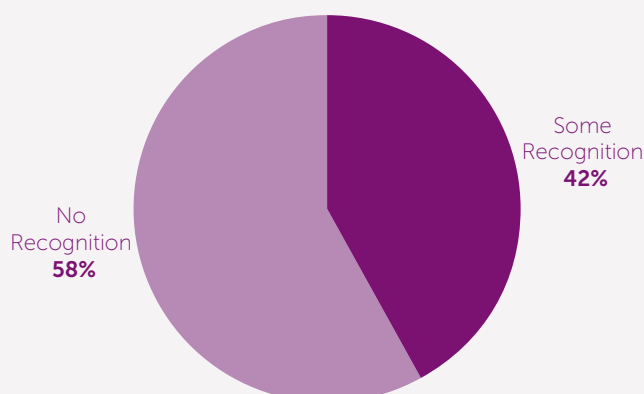
## 2.2.3 REPRESENTATIVE ORGANISATIONS VIEWS ON RESPONSE

Almost two thirds (14) of representative organisations believe that service providers were unable to meet current levels of demand, with over two thirds (73%) agreeing that there is a general lack of understanding of the level of demand from this group. Fifty-five per cent of representative organisation respondents agreed that for service providers, demand pressures are constrained by eligibility criteria, while 77 per cent agreed that under-resourcing constrains service capacity. In light of this, 68 per cent (15) of respondents within the representative organisations group placed strong emphasis on the need for further capacity building and staff training within the service sector.

## 2.2.4 MECHANISMS FOR RESPONDING TO VIOLENCE

A key measure of the capacity of organisations to respond to violence in the lives of their disabled women clients is the presence of an organisational policy, protocol or procedure that specifically recognises the issue of violence against women and girls with disabilities. The majority of service providers (58%) do not recognise this issue in their organisational policies. Of those that do (42%), 57 per cent belong to the domestic violence and sexual assault sector and 20 per cent belong to the disability sector, as Figure 18 shows.

**Figure 18** Recognition of violence against women and girls with disabilities in organisational policies, protocols and procedures





Some service providers emphasised that they do not discriminate in favour or against women and girls with disabilities by identifying or prioritising them in any organisational policies, protocols and procedures. Some services, particularly in the disability system, provide a gender-neutral response, while some exclude women with psychosocial disability. Most procedures and policies are neither gender, disability, nor age-specific. Other service providers noted that they had standard operating procedures for recognising violence that also apply to women and girls with disabilities. Some service providers suggested that agency policies, protocols and procedures need to explicitly recognise that women and girls with disabilities are more vulnerable and that there was a high prevalence of violence among them.

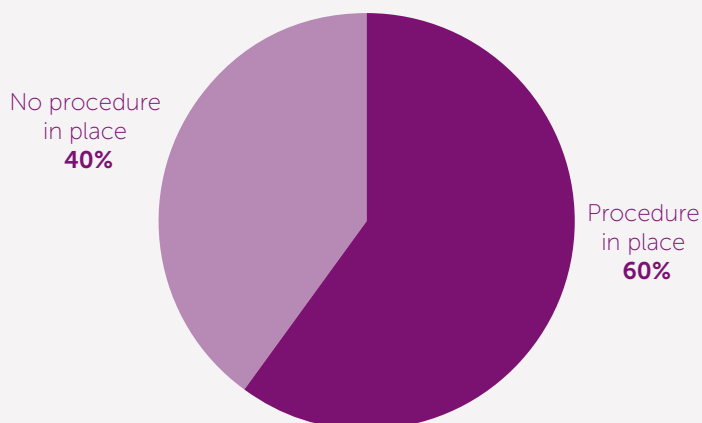
Another key measure of the capacity of services to respond to violence experienced by their female clients with disabilities is the presence of an organisational policy, protocol or procedure for addressing the disclosure of violence or, in the absence of disclosure, a procedure for when their staff suspect that a woman or girl with disabilities is experiencing or is at risk of violence. A significant proportion of service provider respondents to the survey (40%) had no such procedure in place, as Figure 19 indicates.

support services lack formal protocols for staff to follow post-disclosure, as do 43 per cent of legal aid services, 42 per cent of individual advocacy services, and 41 per cent of information and referral services, violence prevention services, government lobbying services and, of particular concern, medical services. Sixty-two per cent of crisis accommodation services and 63 per cent of counselling and mental health services have a procedure in place for when the presence of violence is suspected but not disclosed.

Several service providers identified the need for established protocols in responding to violence against women and girls with disabilities. Health service providers in particular stressed the importance of appropriate screening procedures for detecting violence in the lives of women and girls with disabilities presenting at hospitals and health clinics. Overall, NSW health service providers felt that there was a need for more commitment at the managerial and ministerial level for increasing service capacity for women and girls with disabilities.

In responding to violence against women and girls with disabilities, service providers reported multiple overlapping issues. The lack of education and awareness on what constitutes family and domestic violence is a significant challenge which impacts on the capacity of service providers to substantiate the violence

**Figure 19** Proportion of service providers with a procedure in place for women violence is suspected in the absence of formal disclosure



and intervene in domestic/residential settings. Where substantiating violence is an issue, it was suggested that targeted information be offered to clients and questions asked directly. Some service providers use advocacy agencies for support to disclose. Additional issues identified by some service providers in responding to violence included the lack of basic services in rural and remote areas, particularly public transport for rural communities.

Inadequate police response, a general lack of access to justice for victims and low prosecution rates were identified by some service providers as important issues. Others questioned the prioritising of retribution and punishment over prevention and restorative justice. Overall, service providers agreed on the need for increased legal aid and support for women and girls with disabilities who need access to the criminal justice system. It was felt that better prosecution services and state intervention in child protection as well as family violence orders and assistance in dealing with property issues would benefit them greatly. This was confirmed by a number of representative organisations who suggested that funding the wider use of assistive technology especially in the judicial setting would help address some of the challenges in dealing with perpetrator accountability and inadequate service delivery for victims. People with cognitive disability also require specific supports to assist them in judicial settings.

The use of a one-size-fits all approach by some service providers as well as the under-regulation of service providers particularly in South Australia were seen as important additional issues.

Service providers exhibiting good practice in responding to violence reported that once violence has been disclosed, all evidence is documented, management is alerted, and mandatory reporting is carried out. In these cases, a rapport is built with the victim and a safety action plan is developed in dialogue with them. If the client has an intellectual disability, consent is sought for the process

to be implemented. If support is required from other services, they are resourced and the victim referred. Referrals may be made to social worker, psychologist, or other community service. In cases where providers do not offer the required service, individual advocacy is carried out on behalf of the woman experiencing violence, often in coordination with specific disability services. If medical assistance is required, clients are referred to health services. Where legal intervention is required, this help is sought and the incident is reported to the police. Based on the perceived vulnerability of the client, they are admitted to safe accommodation or hospital. Some services reported carrying out home visits and observations. Others reported providing support for family and inquiring about care and finances. In addition, some service providers reported that they provided information/training on rights, responsibilities and assertiveness for the woman experiencing violence.

Some service providers, particularly those in NT, identified the importance of mandatory reporting requirements when violence is suspected but not disclosed. Other service providers reported that they carried out a risk assessment and if an unsafe environment is observed, the case manager would discuss with the client whether to refer to other services. For young persons, some service providers used a decision making tree to determine the level of risk. Some services reported that they asked the client or the next of kin specific questions especially if medical services reported sexual assault. This is done with the informed consent of the client.

Some violence services, particularly those in Victoria, reported comprehensive procedures for ensuring the safety of clients. Some violence service providers reported that they did not have specific policies for women with disabilities instead they would be treated same as any other women or person who experiences violence. Some suggested the need for mandatory reporting to police and removal of the perpetrator, while other agencies identified their priorities in having staff trained and understand

their duty of care to report such suspicions to concerned authorities.

Service providers were asked to describe any successful anti-violence programs or campaigns they have undertaken to improve services for women and girls with disabilities. Successful programs included support groups run in partnership with women disabilities, in addition to accessible services that are adequately resourced and which adhere to national standards for primary prevention. Taking steps to identify the needs of clients on a case-by-case basis and reduce systemic and personal isolation for women and girls with disabilities are also central to the success of campaigns and programs targeted at preventing violence against women and girls with disabilities.

### 2.2.5 SERVICE ELIGIBILITY AND SERVICE REQUIRED

Almost all (97%) service providers indicated that women and girls with disabilities are eligible to receive their services. Women and girls with disabilities are eligible for 98 per cent of the medical services, community access services, violence prevention services, and safe-at-home services provided by the respondents to the survey. Five per cent of employment services and four per cent of outreach, court support, crisis accommodation and legal aid services reported that women with disabilities are ineligible to receive their services. Almost all (98%) service provider respondents had provided women and girls with disabilities with a service within the past year, although many organisations assisted these women in relatively small numbers. Almost a third (88) had provided less than 19 women and girls with disabilities with a service. Only seventeen per cent of respondents had provided more than 100 women and girls with disabilities with a service in the past year.

## 2.2.6 IMPROVING SERVICE CAPACITY

### SERVICE PROVIDER VIEWS

Service providers were asked to nominate measures they believe would be most effective in assisting them to improve their capacity to improve service delivery for women and girls with disabilities experiencing or at risk of violence. As seen in Figure 20, of the 172 service providers who responded to this question, almost half identified increased service funding as the measure that would most benefit their service capacity and delivery. Many service providers also prioritised accommodation options, suggesting that more women's shelters and medium-term accommodation which can provide for the support needs of women and girls with disabilities are needed. There was also a felt need for specialist facilities for women who have experienced trauma, especially in NSW, particularly as facilities shared with other women and children may not be suitable for women with cognitive or psychosocial disabilities.

There was also a strong emphasis on workforce capacity building, with staff training in violence prevention and disability awareness identified by 15 per cent as the most beneficial measure overall, as shown in Figure 20. The reported need for new forms of training was highest in the housing/homelessness sector, with 80 per cent identifying this as a priority improvement measure, followed by services in domestic violence and sexual assault (59%) and disability service sectors (53%) also identifying training as a high priority. Related to this issue of the need for up-skilling staff, the under-availability of staff training was identified by ten service providers (6%) as the most pressing measure in terms of their ability to respond to the needs of women and girls with disabilities experiencing violence. Fourteen per cent (25) of service providers identified increased infrastructure funding as their priority improvement measure, seventeen of these operate in regional areas.

**Figure 20** Priority measures for service capacity improvement



Seventeen respondents prioritised changes in their organisational mandate over increased funding and further training. Greater flexibility in contractual obligations/outputs was identified by thirteen service providers as their priority measure, twelve of whom provide information and make referrals, eleven of whom provide individual advocacy services, nine of whom provide mental health services, and nine of whom undertake outreach work. As services are often funding driven, some services felt that greater flexibility in funding/contractual obligations such as flexibility to work with non-targeted groups (e.g. women with children) was necessary in order to respond to violence against women and girls with disabilities. Greater flexibility in eligibility criteria and in extending hours of operation was also suggested as a means of improving service capacity to all victims of violence, including women and girls with disabilities.

#### POLICY DEVELOPMENT AGENCY VIEWS ON SERVICE CAPACITY

Some policy makers suggested that even though there were specific policies and programs aimed at preventing violence against women, there were no specific policies or programs aimed at preventing violence against

women and girls with disabilities. However, in some states like Queensland, the domestic and family violence policy and program development includes consideration of the needs of women and girls with disabilities within mainstream policy and programs. The use of risk assessment and family and domestic violence management programs as well as the use of advocacy on issues of particular relevance to women and girls with disabilities such as forced sterilisation was also used by some policy makers to prevent violence against women and girls with disabilities. Other violence prevention mechanisms identified included court attendance, referral to support agencies, behaviour support services, 'feelsafe' interventions and home visits. One policy maker also identified the overarching need for anti-discrimination and equal opportunity regulations as a necessary mechanism for prevention of violence against women and girls with disabilities.

Issues of accessibility to services and accommodation as well as lack of services in some areas and the need for development of referral pathways to family support services have been brought to the attention of policy makers by representative groups, peak bodies and advocacy agencies. Policy makers were also aware that communication barriers between

victims and services are sometimes exacerbated by issues of privacy and confidentiality, especially in relation to carers or family members perpetrating violence.

Policy development agencies recognised specific issues related to legal and justice processes, such as that police have difficulty in obtaining statements from victims with cognitive impairments. Concerns over the admissibility of victim statements in court and implications of this for prosecution have been brought to the attention of policy makers by representative groups, peak bodies and advocacy agencies and as being priorities for incorporation into policy and legislation development. Further priorities identified by policy makers include the development of operational guidelines detailing duty of care, and the current lack of a workable framework for reporting, confidentiality, consent, guardianship and protection of victims.

When asked about the policy changes that would be required to enable better service responses to issues of violence against women and girls with disabilities, some policy makers identified the need for firmer political commitment. Others highlighted the pressing issue of availability of accessible housing and accommodation as crucial to enabling better service responses for women and girls with disabilities who are affected by violence. The reversal of policies on removal of victims rather than the perpetrator was a suggested priority as was the need for reducing the burden of proof for victims to enable more appropriate and effective service response.

---

#### REPRESENTATIVE ORGANISATION VIEWS ON SERVICE CAPACITY

---

Representative organisations were asked about the efficacy of service system responses to violence against women and girls with disabilities. The overall perception amongst these respondents was that neither the violence sector nor the disability sector responds adequately to the needs of this group. Service responses within the disability sector appear

particularly poor when violence against women and girls with disabilities has been perpetrated but not disclosed, which reflects that sector's need for further training in recognising and responding to violence.

Eighty-two per cent of representative organisations perceive there to be no clear, well-defined pathways to safety and support for women and girls with disabilities experiencing or at risk of violence. Establishing a more structured and more appropriate referral pathway that addresses housing/accommodation needs was seen by service providers as a means of increasing service capacity for women and girls with disabilities. All but one respondent agreed that gaps in the service system prevent this group from accessing appropriate services, and that duplication of services is not a realistic concern. There was also strong consensus that successful inter-agency violence prevention work aimed at women and girls with disabilities will require additional resources from government and a clearer framework for collaboration between service sectors.

Representative organisations unanimously indicated that they believe that adopting a human rights approach to service delivery and policy development would benefit women and girls with disabilities experiencing or at risk of violence, with one noting that "at present, the gaps in the service system as they relate to this group demonstrate a lack of commitment to the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Elimination of All Forms of Discrimination (CEDAW), both of which Australia has ratified but not effectively legislated".

From a representative standpoint, there is some concern around workforce capacity and the ability of staff to identify and respond to the breadth and depth of issues that may be present when dealing with the intersection of gender, disability and violence. Of particular concern to representative organisations is the lack of understanding at the service provider level of

issues around intersectional discrimination, that is, discrimination based on some mix of gender, race, class, ethnicity, sexual orientation, ability, age, language group, and/or religious beliefs.

There is also some concern from representative organisations over the low rates of sexual assault prosecution where victims have cognitive/communication disabilities, who often face a number of evidential barriers, including police stereotypes about 'good witnesses'. Some representative organisations suggested the need for consistent laws across jurisdictions. Others emphasised the need for policy and legislation changes to build access and gender into accreditation and funding arrangements, while some organisations felt the need for a funded and well-coordinated response to violence against women that is not about just homelessness or perpetrators, but which recognises the significant flow on impacts on the health, mental health and justice/child protection systems in a way that it recognises financial costs and disincentives to women escaping violence. Such a response should make it easier for women and girls with disabilities escaping violence to stay in their own homes and the perpetrator of violence to be removed.

## 2.3 SUMMARY IMPLICATIONS

- The survey findings indicate that the mental health sector is a key primary site that women and girls with disabilities utilise and disclose their experiences of violence, both current and past. Mental health services reported overall that they are responding to demand appropriately. It appears that they may be better equipped to respond appropriately and effectively to this group because they are able to recognise violence as a key determining factor in shaping service demand by user groups. Thus, mental health services appear to be one of the few services that can readily support women and girls with disabilities to an effective pathway to safety.
- The issue of resources, including adequate targeting of resources to address the specific issue for the particular client group has a range of implications to responding in a timely, effective and appropriate manner. Nearly all services indicated that they do not have adequate resources to effectively respond. Resources here were contextual, environmental and organisational. For example, many services suggested that responding appropriately to identified violence within informal care arrangements would have implications for their services as it would place the responsibility of disability support onto their services, which in most instances, they were unable to pick up due to organisational resource or funding constraints.
- Managing the demands for residential services of any kind is particularly challenging, resulting in women and girls with disabilities either having to remain where they are (in violent situations); or be forced to move to another potentially violent situation in emergency accommodation. Respondents to case scenarios in the survey identified common experiences for women with disabilities in which police were reluctant to get involved with violence cases against women and girls with disabilities, in both formal and informal arrangements, as the police could not readily identify and access safe accommodation options for women and girls with disabilities who are affected by violence with whom they had contact. This problem is known to be particularly acute for people with an abusive attendant carer (where the primary carer is also the abuser).
- The current division of services as administered under discrete domains of gender, violence, or disability and so on, places women and girls with disabilities who are at risk of or are experiencing violence outside the service system, as they often have needs placed outside the prescribed 'norm' within each of these



systems. A key implication of this is that services are not required to respond to the broader issues that may surround the person outside their single 'contractual' tag and in turn, placing them outside the remit of the service.

- It appears that one of the few responses currently available for services is to 'refer on' to other services. However, this does not mean that those individuals referred will receive a service response as required that is appropriate and timely. There is a concern that services may be 'referring' women and girls with disabilities to inappropriate services or that this service response is repeated to the extent that women with disabilities become caught in a cycle of successive referral, without ever receiving appropriate or timely interventions that ensure their pathway to safety or supports their wellbeing. In many instances, it is known that the frustration with this ineffective service response results in women no longer making contact with the service system and remaining in situations of violence. This highlights the need to resource agencies to develop greater reciprocal linkages or partnerships across the disability, family violence and sexual assault sectors, using local networks and encouraging local preventative and intervention initiatives that support women and girls with disabilities.

- Representative organisations had a strong consensus on the need for inter-agency collaboration and establishing a framework for violence intervention and prevention to move forward to explore potential new avenues in which partnerships can be built for effective response systems.
- One of the primary systemic issues identified is that definitions of domestic violence within existing domestic legislation do not cover the specific domestic situations and relationships that women with disability are often in. The issue here is that if there is no legal recognition of the problem as a cross-sectional issue, then it is unlikely to be given priority within a service environment, where services are largely governed by a range of specific legislative frameworks specifically designed to ensure effective but separate service delivery.

## THEME 3 INCLUSION AND PARTICIPATION

### 3.1 CONTEXT

The issue of inclusion and participation of women and girls with disabilities in directing their own lives is a strong underpinning principle of the STVP and has been canvassed through both the survey and through the stakeholder consultations with women with disabilities. Participation by women and girls with disabilities in the planning and implementation of services is necessary if the services are to be effective in addressing issues of violence against them.

Both gender and disability based assumptions, stereotypes and prejudice generally place women and girls with disability at a disadvantage with respect to substantive enjoyment of basic human rights. In the context of violence prevention and response policies and programs, such stereotypes and assumptions can result in women and girls with disabilities being viewed as 'victims in need of protection' rather than as equal, active partners in the development of solutions. Women with disabilities are often denied or limited in their freedom to act and be recognised as autonomous, fully capable adults, to participate fully in economic, social and political development, and to make decisions concerning their circumstances and conditions. Girls with disability are often denied or limited in expressing their views in line with their evolving capacities, and are perceived as 'fixed' in their capacities to understand or participate in decision-making affecting their lives.

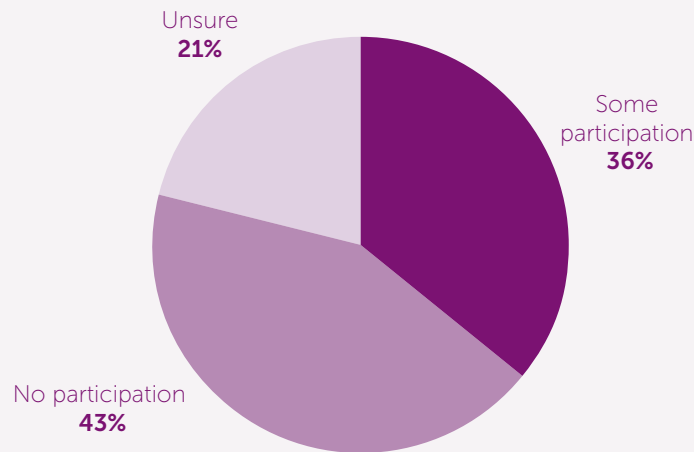
The need for women and girls with disabilities to be meaningfully involved in the design, implementation, monitoring and evaluation of targeted measures to address violence is critical to realising their human rights. Australia's obligations under several international human rights treaties, including the CRPD, CEDAW and the Convention on the Rights of the Child (CRC), also recognise participation of marginalised groups, such as women and girls with disabilities, in the conduct of public affairs and policy development as a human right.

### 3.2 EVIDENCE

#### 3.2.1 INCLUSION IN SERVICE PROVISION

In reflecting on the mechanisms currently in place within the service domain, service providers were asked about how they include women and girls with disabilities in the planning and development of their services. Of the 165 service provider respondents who addressed this question, 57 or just over one third of these (36%) indicated that there was some participation by women and girls with disabilities in service development and planning in their organisations, as Figure 21 illustrates. Of these service providers, 37 per cent or 22 were disability services and 29 per cent or 17 were domestic violence and sexual assault services. Of concern is that in just under half (44%) of the organisations there was no participation and a further third (34%) were unsure whether there was any such participation.

**Figure 21** Participation of WGWD in service development and planning



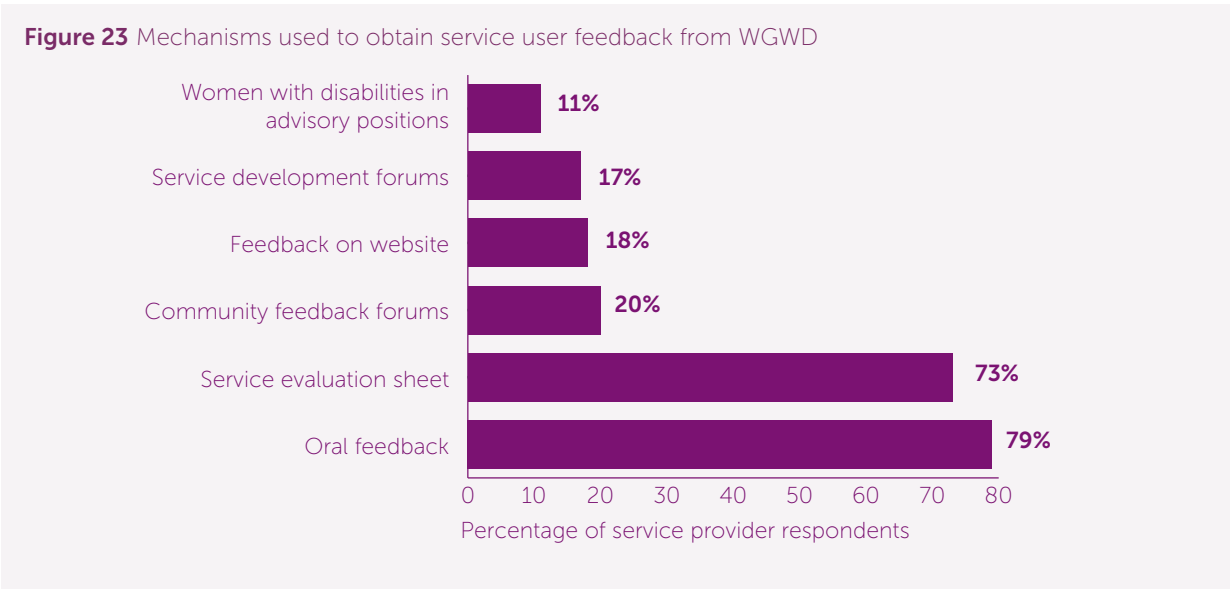
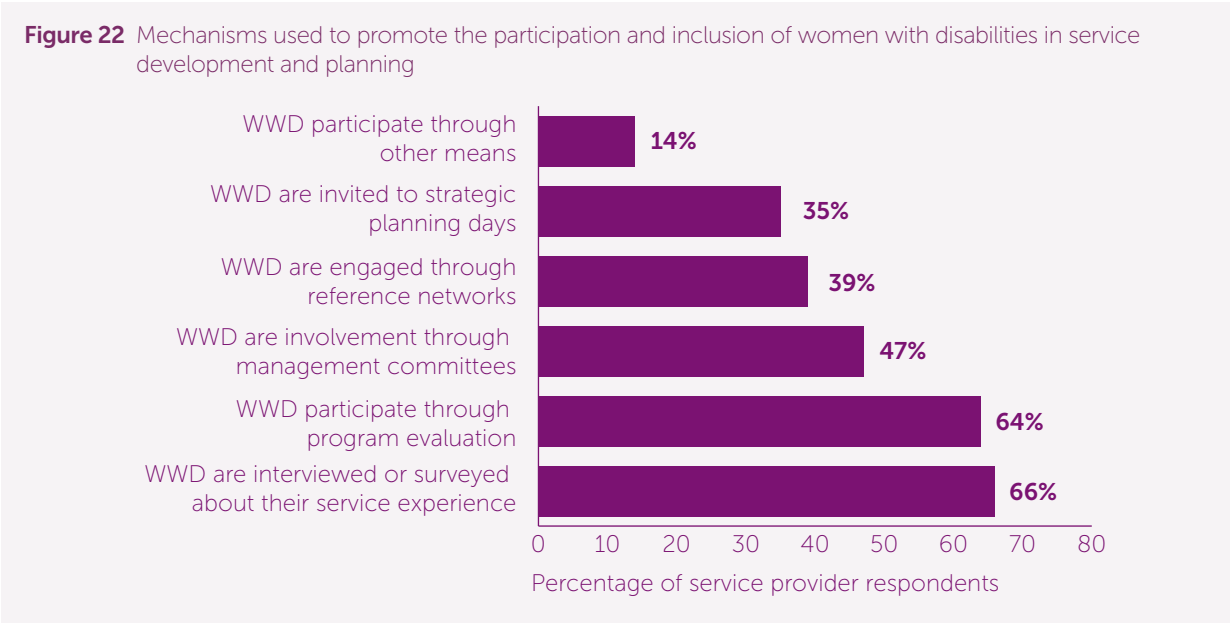
This is particularly concerning given that women and girls with disabilities are a significant and a recurrent service user group amongst the survey respondents. Ninety-seven per cent or 217 of the respondents provide services for which women and girls with disabilities are eligible, and the overwhelming majority (98%) or 220 of the service provider respondents had provided women and girls with disabilities with a service within the past year.

For the 59 organisations that did facilitate participation and inclusion (see Figure 22) two thirds (66%) or 39 organisations interviewed or surveyed women and girls with disabilities about their service experience. Roughly the same proportion (64%) or 38 organisations involved them in program evaluations and almost half (47%) or 28 organisations engaged women and girls with disabilities through management committees or advisory boards.

Half of the 28 organisations that engage women with disabilities in a management or advisory capacity are disability service providers. Only 20 organisations involved women and girls with disabilities in strategic planning and only one of these was a violence service provider. Eleven per cent or 17 service providers had women and girls with disabilities in advisory positions, seven of whom were disability services and only three of whom were domestic violence and sexual assault services. It appears then that some service providers prioritise inclusion and participation of women with disabilities through a range of mechanisms, and this is generally better done by disability service providers. Overall, inclusion and participation in the planning and development of services to meet their needs appears to occur at relatively low levels across the range of services which are accessed by women and girls with disabilities.

In the specific domain of service evaluation the survey explored the presence and nature of mechanisms in place for women and girls with disabilities to provide feedback on their experiences of the service system. Findings show that the overwhelming majority (93%) of service providers reported having feedback mechanisms in place for women service users with disabilities. The most common mechanisms used were oral feedback (79%) and service evaluation sheets (73%). Findings suggest

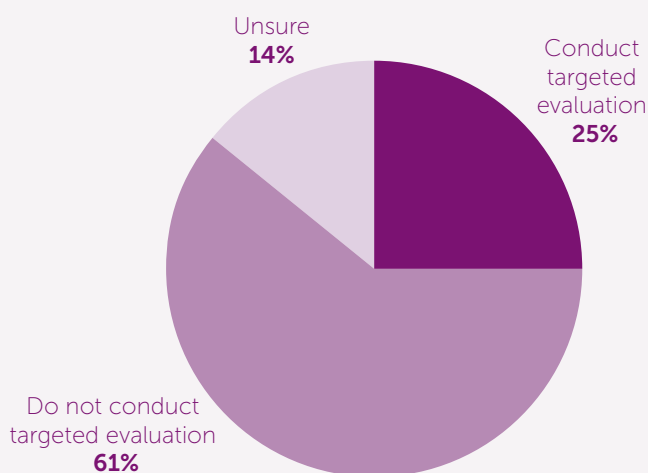
that those who use oral feedback and service evaluation sheets tend to offer and apply them on a universal basis, but do not have in place a mechanism specifically designed to capture the experiences or opinions of women and girls with disabilities. This is of particular concern in light of the potential access and support needs of women with disabilities who may require alternative formats or have difficulties communicating verbally.



Service providers were also asked whether and how they evaluate the performance of their services with respect to the specific needs of women and girls with disabilities. Of the 161 organisations (58%) who responded to this question, a quarter reported that they do conduct targeted evaluation. As Figure 23 suggests, however, the majority of these organisations pursue a 'one-size-fits-all' feedback strategy, given that a more targeted and resource intensive evaluation process is not a legislative requirement of their service. This is reflected in the fact that the majority (61%) or 98 organisations do not tailor their service evaluation in any way to the needs of women and girls with disabilities, and 14 per cent or 23 organisations are unsure if any such evaluation occurs at all, as shown in Figure 24.

The survey also sought information from service providers on the physical environments in which services and programs operate and whether these are appropriate and accessible to women and girls with disabilities. As Figure 25 shows, of the 165 service providers that provided this information, the overwhelming majority (81%) reported that the building in which they operate has accessible doorways and thoroughfares. Sixty eight per cent of organisations provide information in plain-English and/or easy read format, 61 per cent provide ramps, 59 per cent provide clear signage and 56 per cent support workers on hand. A minority of organisations provide accessible transport (32%), sign language interpreting (28%), teleprinter or teletype facilities (10%) and emergency attendant care (7%).

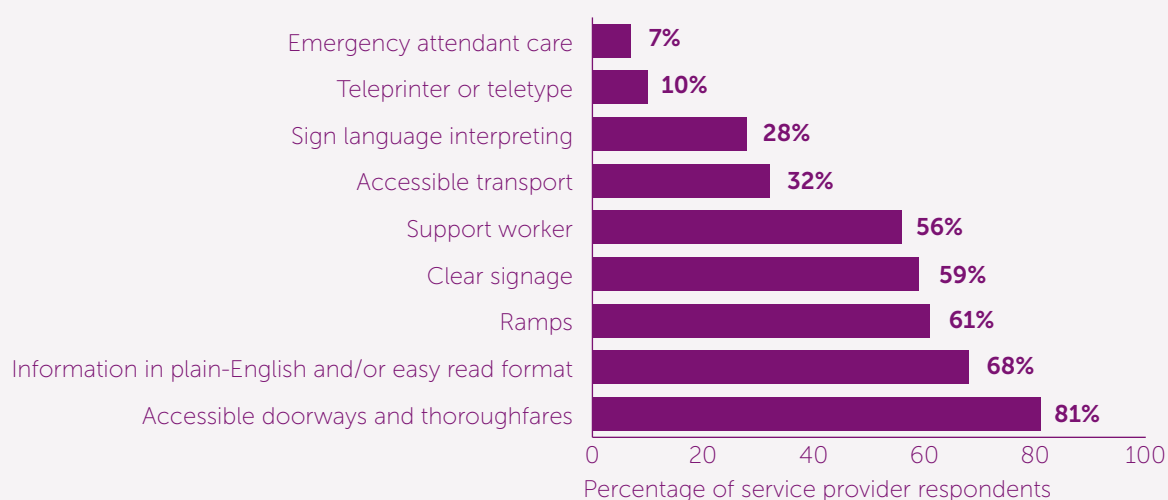
**Figure 24** Service evaluation targeted to the needs of WGWD



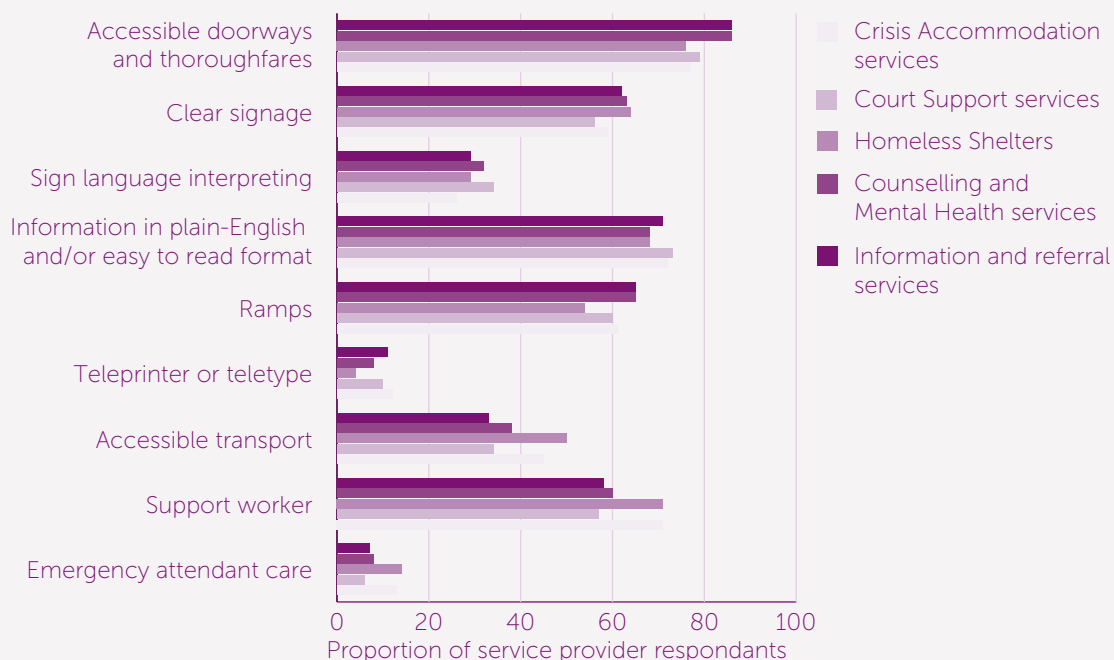
As Figure 26 indicates, more resource intensive supports such as emergency attendant care and accessible transport are lacking, and this is particularly so for housing services such as crisis accommodation and homeless shelters. Other necessary victim support services such as court support, counselling and mental health

services, and information and referral services are also lacking for this group. Further, less than 12 per cent of these services offer teleprinter or teletype facilities, as a basic accessibility measure for women with hearing impairment or who are deaf.

**Figure 25** Facilities and services provided to ensure accessibility



**Figure 26** Facilities and services offered by violence and disability services





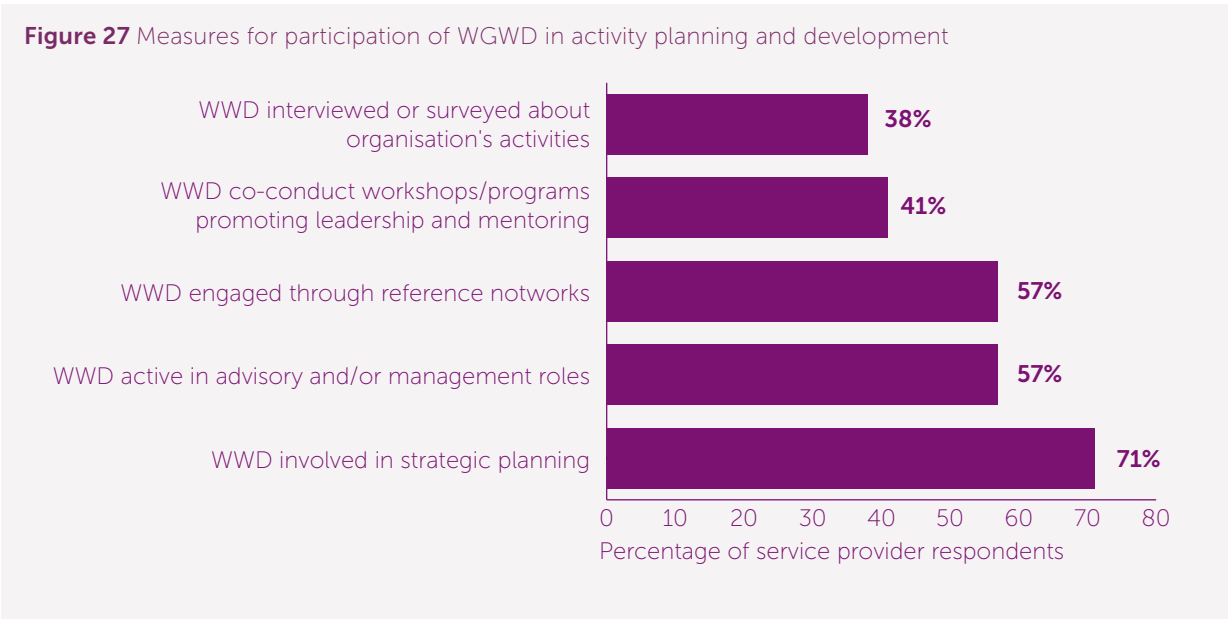
The findings generally support the proposition that including women and girls with disabilities in planning services assists in increasing service capacity for those affected by violence. Service providers felt that interaction and inclusion of women and girls with disabilities in planning campaigns and programs were essential for the successful implementation of such campaigns and programs aimed at preventing violence against women and girls with disabilities. Ensuring that their voices were heard and respecting and considering differences was also identified as essential by some service providers. Additionally, a number of service providers felt that women and girls with disabilities should be involved in training sessions for staff and in program delivery in order to contribute to the success of campaigns and programs aimed at preventing violence by service providers.

### 3.2.2 INCLUSION IN REPRESENTATIVE ORGANISATIONS

Representative organisations identified whether and how they facilitate the participation of women and girls with disabilities in the development and planning of their activities.

The majority (73%) or 19 organisations report some level of participation. Of these, fifteen organisations include women with disabilities in strategic planning, and twelve engage them through reference networks and/or have women with disabilities in advisory or management roles. Of the eleven representative organisations that involve women with disabilities in an advisory or management capacity, six belong to the disability sector, three to the domestic violence and sexual assault sectors and one to the legal and health sectors respectively. Of the fourteen representative organisations that involve women with disabilities in strategic planning, eight belong to the disability sector, three to the domestic violence and sexual assault sectors, two to the health sector, one to the legal sector and one to the welfare sector.

As Figure 27 suggests, fewer (9) organisations harness the skills and experiences of women and girls with disabilities by involving them in leadership/mentor programs (41%) and only 8 (38%) organisations directly consult or survey women with disabilities about their organisation's activities.



A number of representative organisations who responded were involved in raising awareness on domestic violence and abuse of women and girls with disabilities to service providers through consultancies or through conducting research and training projects directed at preventing violence, or by conducting workshops for women and girls with disabilities to explore and express their own experiences of violence. Other representative organisations represented the interests of women and girls with disabilities by advocating for a gendered analysis in legislation, policy and practice reform at all levels of government using a CRPD framework.

### 3.2.3 INCLUSION IN POLICY MAKING

Involvement of women and girls with disabilities in the planning and development of policies and programs were seen by most policy makers as necessary to enable better service responses to issues of violence against women and girls with disabilities. An example of this type of inclusion could be seen in efforts to create greater community awareness on issues of violence against women and girls with disabilities through community/public forums. All respondent groups reported that women with disabilities had a significant role to play in contributing to the development these approaches and in general that more resources were needed to realise this goal both in terms of supporting women's involvement and in funding awareness and prevention programs and campaigns themselves. These various engagements in policy making were also highlighted as an important need by the participants of the stakeholder engagement forums conducted by the STVP. Lack of inclusion of women and girls with disabilities in policy development, service design and delivery as well as the lack of opportunity to hold governments' accountable were some of the reasons suggested as causing fragmentation and/or duplication of services for women and girls experiencing or at risk of violence.

## 3.3 SUMMARY IMPLICATIONS

- It is clear from the survey findings that all respondent groups struggle with fully realising the goal of participation and inclusion of women with disabilities in their practice. How to operationalise the notion of participatory and inclusive decision-making in service and policy contexts remains unclear for most respondents. This is further compounded once issues located at the intersection of gender, disability and violence are viewed in terms of the violation of human rights. Organisations do not necessarily understand violence against women with disabilities as a human rights issue and have difficulty incorporating this understanding into their organisational frameworks and practices. As suggested by the survey findings, for example, many services do not view inclusive and participatory decision-making with women and girls with disabilities as a critical component of their service mandate.
- The lack of participation within the service system around key aspects of design, evaluation and implementation, and the lack of understanding about inclusive participatory decision making roles in ensuring gendered-disability inclusive service design, may explain the significantly low rates of gendered-disability violence recognition and response.
- Participation for women and girls with disabilities is not just about participation in planning at the service level, but it also includes the need for an affirmative approach to participation in policy making and decision making across all levels. Such an approach would require special measures and initiatives to be instituted at the policy level, as provided for under CEDAW and the *Sexual Discrimination Act 1984* (Cth). Currently participation at the policy level is inclusive of mainly representative organisations rather than broad range inclusion of women and girls

with disabilities within decision-making processes of relevance.

- There appears to be a lack of understanding by some service providers of the need for a gendered disability framework. Some service providers appear to see people with disability as a homogenous group and feel that applying a gender-based 'lens' to issues of disability and violence may be a discriminatory practice. It appears that the scene is not set within the policy environment for services to incorporate these issues into their operational frameworks.
- Inclusion and participation of women and girls with disabilities in policy and program development as well as development of legislation is an important obligation under international human rights commitments made by the Australian Government under CEDAW, CRC and CRPD. It appears limited attention is paid to issues located at the intersection of gender and disability in enacting these treaties in the realms of policy and service planning and delivery. Particularly relevant here is the design, implementation and governance of NDIS.

## THEME 4 SECTOR DEVELOPMENT

### 4.1 CONTEXT

The need for the overall development of service sectors dealing with the intersection of gender, disability and violence was one of the key common needs identified by all respondent groups across the survey. Issues emerged around workforce capacity and the ability of staff to identify and respond to the breadth and depth of issues that may be present when addressing these intersectional issues. The survey explored the types and extent of training undertaken by the range of service providers, particularly in violence awareness, violence prevention and disability awareness.

### 4.2 EVIDENCE

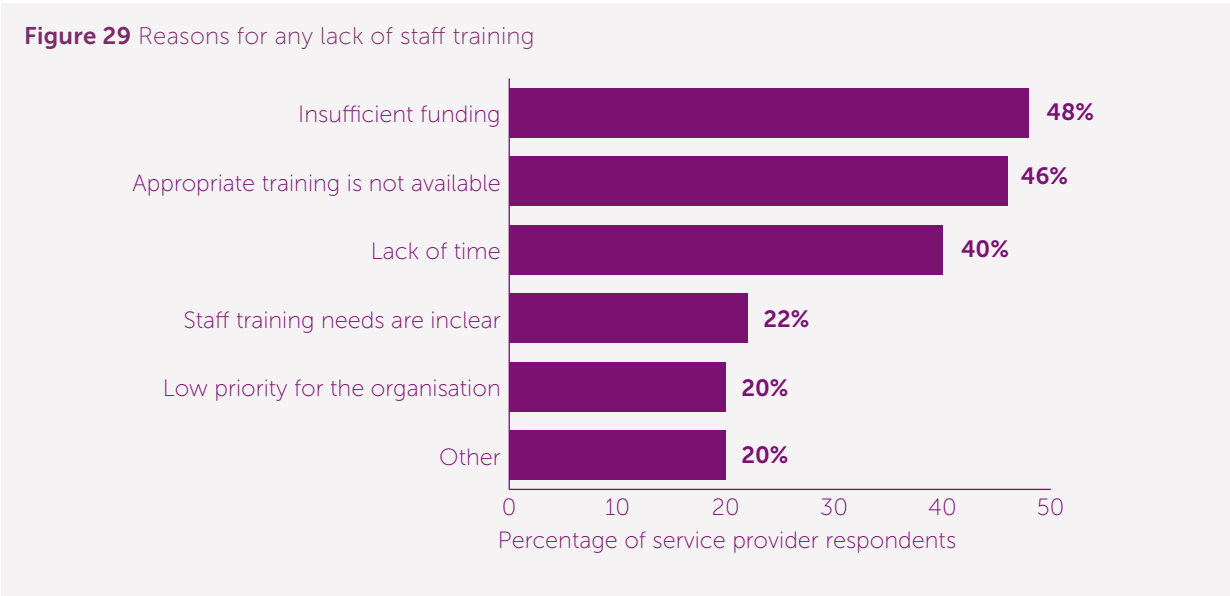
#### 4.2.1 LEVELS OF STAFF TRAINING

Around half of the service provider respondents to the survey (142) provided information on staff training, while half did not provide this information. Of the 121 who did, 85 per cent had undertaken some level of *violence awareness* training within the past five years, as Figure 28 indicates. Forty-five per cent (55) of domestic violence and sexual assault services had undertaken this type of training, as had thirty-seven per cent (26) of disability services. Routine *violence prevention* training was less widespread amongst service providers; 28 (20%) organisations reported no training in this area, 10 of whom provide disability services, and twelve of whom are small organisations with less than 20 staff. Sixty-eight per cent (96) of all service providers had undertaken some level of *disability awareness training*. Of the 41 organisations who reported that they had not

undertaken any training in disability awareness, over half were small organisations, more than half provided counselling and mental health services, and almost half belong to the violence sector. Less than a third (89) of all service providers had undertaken both disability and violence awareness training.

4.2.2 BARRIERS TO TRAINING

As shown in Figure 29, insufficient funding was cited as the main reason for any lack of staff training in these areas, followed by the unavailability of training opportunities/expertise and lack of time. Findings suggest that service providers are aware of their staff training needs and do prioritise, or would like to prioritise, capacity building and skills sharing.



### 4.2.3 TRAINING NEEDS

Service providers surveyed recognised the need for increased training on all aspects of domestic and family violence for workers in disability services. Routine in-service training and continuing education for all existing staff to update their skills to meet current service needs was identified as important. Lack of experience and limited availability of formal supervision arrangements to ensure competency and skills base of the staff were a concern for service providers.

Specialist skills in handling trauma, violence, mental health and disability were required for staff working in all services dealing with women and girls with disabilities as were age-specific specialist skills. In order to provide appropriate responses for all clients accessing services, training of staff on responding to disclosure of violence and training for management staff on supervising such matters was identified.

Some service providers indicated that government initiatives, policies and funding arrangements under which they work pose challenges in terms of cross-sector training for staff and also contribute towards inadequate staffing levels. Others cited lack of funding as posing the problem of insufficient resources for staff training and networking with other service providers.

Lack of professional knowledge and skills among professionals in the different fields to work with people with disabilities have been brought to the attention of policy makers by representative groups, peak bodies and advocacy agencies. There is a perception that some professionals lack knowledge of policies and practices to be followed when a woman discloses violence, and some are not skilled to deal with trauma.

Sector capacity building was an issue addressed in the advocacy work undertaken by organisations representing the interests of women and girls with disabilities, including the need for enhanced capacity in local

organisations and in training service providers. When asked about the challenges they faced in terms of government legislation and policy in relation to gender, disability, violence, some representative organisations suggested that they were unable to effectively contribute to broader policy and sectoral change processes due to the demands of their other areas of service delivery.

In relation to the efficacy and capacity of current service sectors to effectively address the service needs of women and girls with disabilities experiencing or at risk of violence, representative organisations cited lack of skills and knowledge of the rights of women and girls with disabilities as a root cause of fragmentation and/or duplication of services. Some representative organisations also felt that lack of skills in health and mental health services around trauma led to fragmentation and/or duplication of services for women and girls with disabilities experiencing or at risk of violence. Representative organisations also identified issues such as lack of knowledge in workers in group homes, lack of knowledge by GPs in dealing with mental health issues such as trauma and the limited capacity of all sectors to respond with quality care as key reasons preventing women and girls with disabilities who have experienced violence from accessing appropriate and responsive support services.

## 4.3 SUMMARY IMPLICATIONS

- Services have little capacity and staff capabilities to respond to violence against women and girls with disabilities, including those in the violence sector and the disability sector. Almost all service provider respondents identify that extensive sector development is needed to:
  - a) cater for this population group effectively more generally; and
  - b) recognise, respond and address violence when and where it occurs in a timely, effective and appropriate manner.

- A very obvious concern emerging from the survey is that very few services felt that they had the 'know-how' in terms of:
  - a)** a readily identifiable skill set overall;
  - b)** available organisational policy and procedures;
  - c)** accessibility from a disability perspective; and
  - d)** a broader awareness in the organisational culture of the issue to promote effective recognition of violence against women and girls with disabilities.

The overall capacity of the combined service response sector needs to be developed in order to promote a cultural shift to appropriately address the needs of women and girls with disabilities in both the short and long term. This required as a part of a global response to the issue rather than just staff training.

- It was noted that most staff do not receive training in the areas of violence against women or disability, let alone training to promote awareness of the specific issue of violence against women and girls with disabilities. Further, women with disabilities themselves have not been provided with the relevant information to identify violence, or risks of violence, occurring within their lives. In many cases redress is not actively pursued and women and girls with disabilities continue living at risk of harm. Services that are funded to support this group in some capacity are often unable to recognise covert forms of violence, and therefore rely upon women with disabilities, including women with complex communication needs, to disclose such violence. This extends to recognising the signs of violence and abuse in people who do not have spoken language due to intellectual disability. In many of these cases, parents and caregivers 'know

something is wrong' but issues are not investigated. This indicates a need for professionals working in all relevant sectors to undertake targeted training in recognising and responding to violence that occurs specifically within the lives of women with disabilities. Such training programs should operate in addition to those that seek to address violence against women and the supports needed for people with disability as two separate areas of need.

- It is clear that front line staff require extensive knowledge, expertise and competence to ensure that services adequately responded to the issue. One of the key issues facing services in the area is that many supervisory and management staff are also not aware of the issue. The lack of knowledge, expertise and skills among supervisory level staff means that the service provision staff do not necessarily get the best level of advice or training in the area. It may also mean that staff are not necessarily encouraged to actively respond to instances of violence for this population group when they present to their service.
- In order to develop a responsive and effective services sector, there is a need for higher levels of inclusive participation by women and girls with disabilities. Structures and supports for this need to be properly resourced and women with disabilities themselves need to be connected through networks to be able to participate and contribute to overall sectoral development.



## THEME 5 CROSS-SECTOR COLLABORATION

### 5.1 CONTEXT

A key issue identified within the international literature relates to the design, development and implementation of effective service provision to prevent and address violence against women and girls with disabilities. In particular, literature highlights that violence against women and girls with disabilities is typically difficult to address as it does not fall neatly into either of the two key policy and service arenas dealing with violence against women, that is; domestic and family violence services and sexual assault services nor the disability services sector.

All three groups of respondents to the national survey have identified cross-sector collaboration a key issues requiring resolution to ensure effective service response to violence against women with disabilities. Service providers, representative organisations and policy makers all provided information about the nature of cross-agency collaboration within their own sector and also, cross-sector collaboration

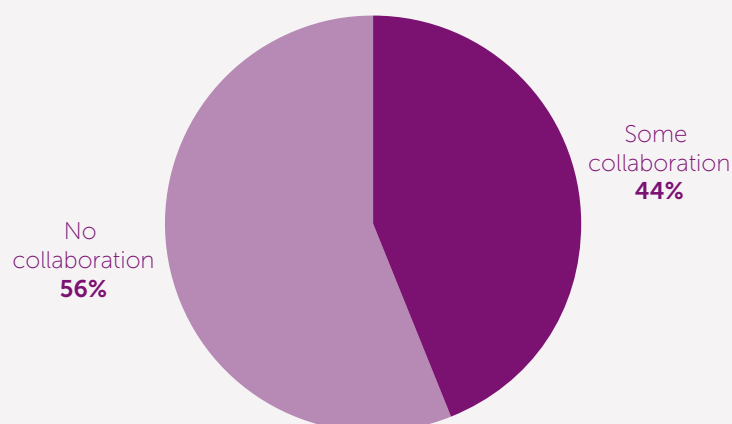
with organisations working in sectors outside their own. The picture emerging indicates that whilst the need for cross-sector collaboration is clear, currently there is no policy framework within which this can occur. Further, where there are mechanisms in place for cross-sector collaboration to potentially occur, these are largely informal and ad hoc in manner, driven largely and initiated by local staff in response to local need.

### 5.2 EVIDENCE

#### 5.2.1 SERVICE PROVIDER COLLABORATION

One hundred and forty-one service provider organisations supplied information about the nature of their cross-agency and cross-sector collaboration. The majority of these organisations (79) reported that they do not undertake any activities of this kind. Forty four per cent reported some level of cross-agency collaboration on issues to do with violence against women and girls with disabilities. Only 17 per cent of disability service providers reported collaboration with other disability services. Collaboration appears much more common between domestic violence and sexual assault services, as Figure 30 indicates.

**Figure 30** Cross-agency collaboration on violence against women with disabilities



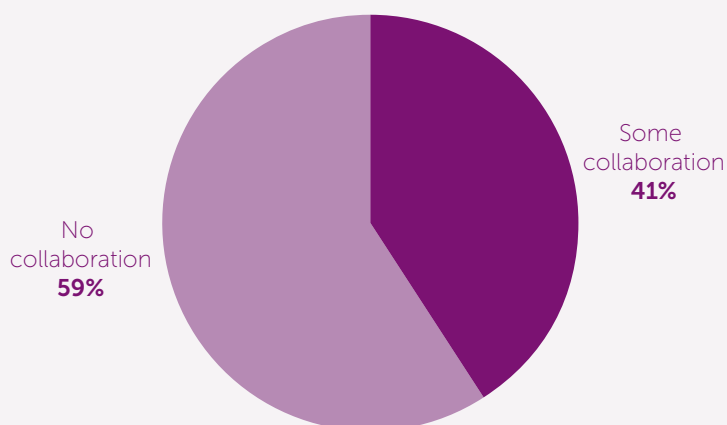
Collaboration between different sectors on issues to do with violence against women and girls with disabilities is less prevalent, with 59 per cent reporting no such collaboration. As Figure 31 indicates, only 10 disability services reported any cross-sector collaboration, however, eighty-eight per cent (29) stated they would like to collaborate more with violence services. Similarly, violence services expressed interest in working more collaboratively with disability and mental health services to better address the specific needs of women and girls with disabilities experiencing or at risk of violence. Lack of coordination and collaboration between the disability sector and the violence sector has maintained separation and reinforced the fragmentation of services, particularly for women and girl victims with disabilities who experience additional types of discrimination or disadvantage due to poverty, race, ethnicity,

religion, language, or other dimensions of social disadvantage or life experience. This is similarly the case for children's and family services.

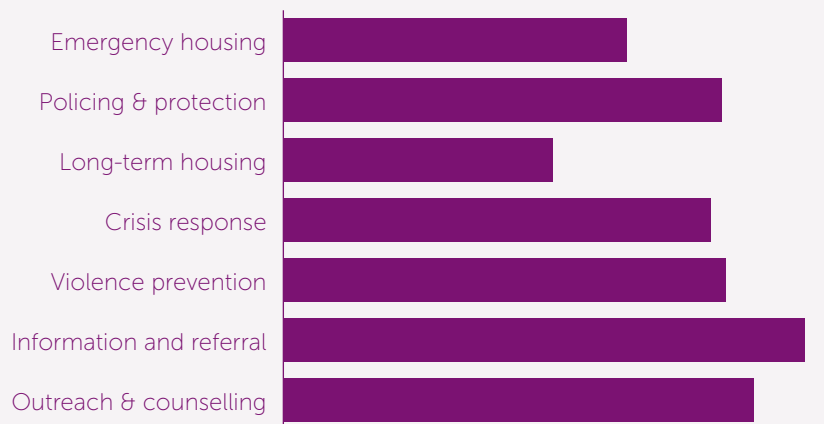
No service providers funded by church or charity groups or private contributions engage in any cross-sector collaboration, suggesting that this sector in particular would benefit from a clearer framework for collaboration and cooperation that was regulated through inter-sector agreements.

As Figures 32 and 33 suggest, where collaboration does occur, it is mainly around the provision of information, referral and counselling services. Significantly less collaboration occurs around direct intervention and prevention services such as crisis response, long-term housing, policing and protection and emergency housing, although in Victoria some considerable gains have been made in this area.

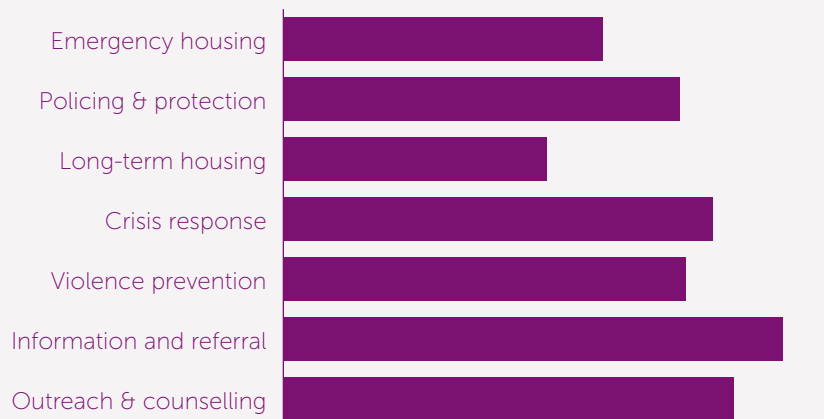
**Figure 31** Inter-sector collaboration on violence against women with disabilities



**Figure 32** Level of inter-agency collaboration on violence against women and girls with disabilities



**Figure 33** Level of inter-sector collaboration on violence against women and girls with disabilities



Half of all service provider respondents stated they would like to work collaboratively with other providers to better address and respond to the needs of women and girls with disabilities who are experiencing or at risk of violence. Towards this end, 67 per cent of disability services stated they would like to collaborate more with other disability services, and 89 per cent stated they would like to collaborate more with domestic violence and sexual assault services. Similarly, 55 per cent of domestic violence and sexual assault services stated they would like to collaborate more with other services within their sector, and 87 per cent stated they would like to collaborate more with disability services.

One of the primary suggestions for improvement in this area pertained to the need for greater collaboration between the disability sector and the violence against women sector at the level of policy and front-line service delivery. Services and representative groups suggested that the current lack of coordination poses significant threats to providing effective, responsive and timely services to women and girls with disabilities experiencing or at risk of experience violence. Some representative organisations suggested that where fragmentation of services exists, this is caused by the lack of clear practice guidelines and coordination between the disability and violence sectors.

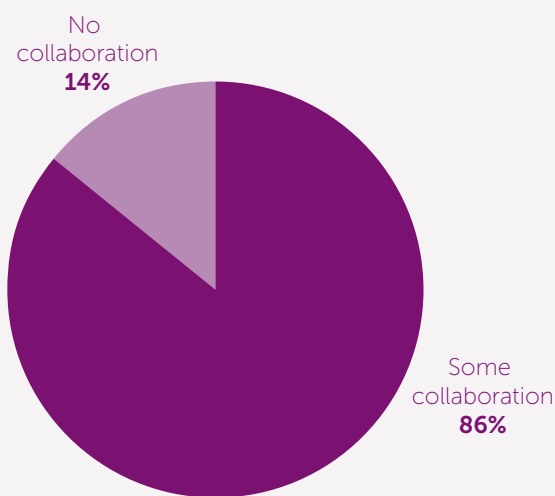
Many respondents recognised that women and girls with disabilities are particularly susceptible to violence due to their relationships with family members and carers. They therefore identified a strong need for services that women with disabilities in violent intimate partner or carer relationships can access from/in-home, for example, Victoria's safe-at-home program. Additionally, service providers and representative organisations also stated that greater collaboration is required between disability, violence and legal services to ensure that victims have the appropriate supports to pursue legal proceedings against perpetrators should they choose to.

### 5.2.2 POLICY AGENCY COLLABORATION

Fourteen policy development agencies also provided information about their level of collaboration on responding to violence against women and girls with disabilities. Eighty-six per cent of agencies reported collaborating with other policy agencies within their portfolio area, as Figure 34 indicates.

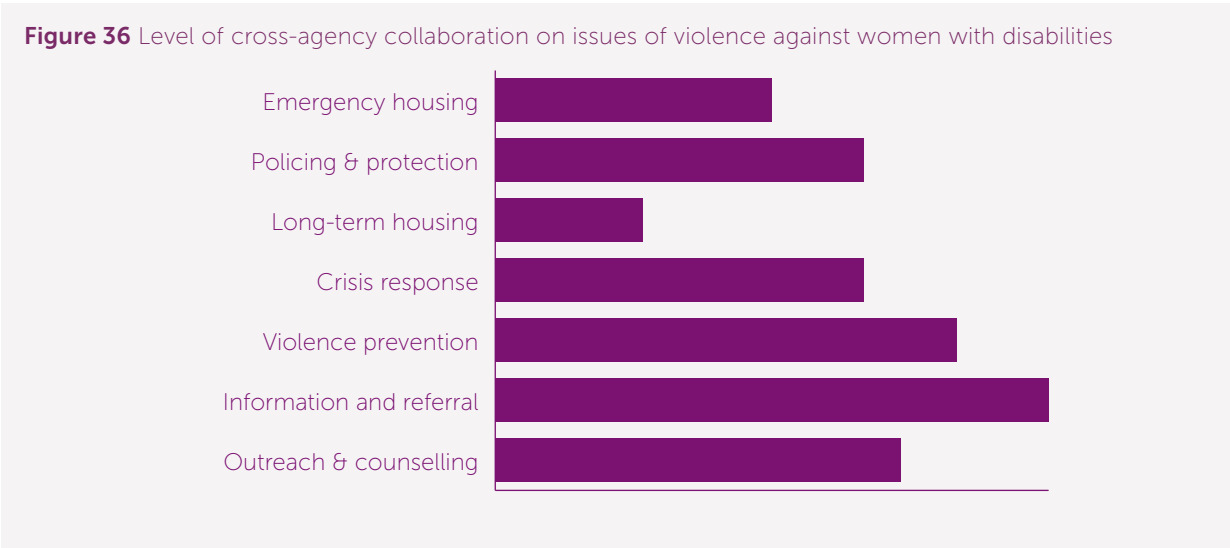
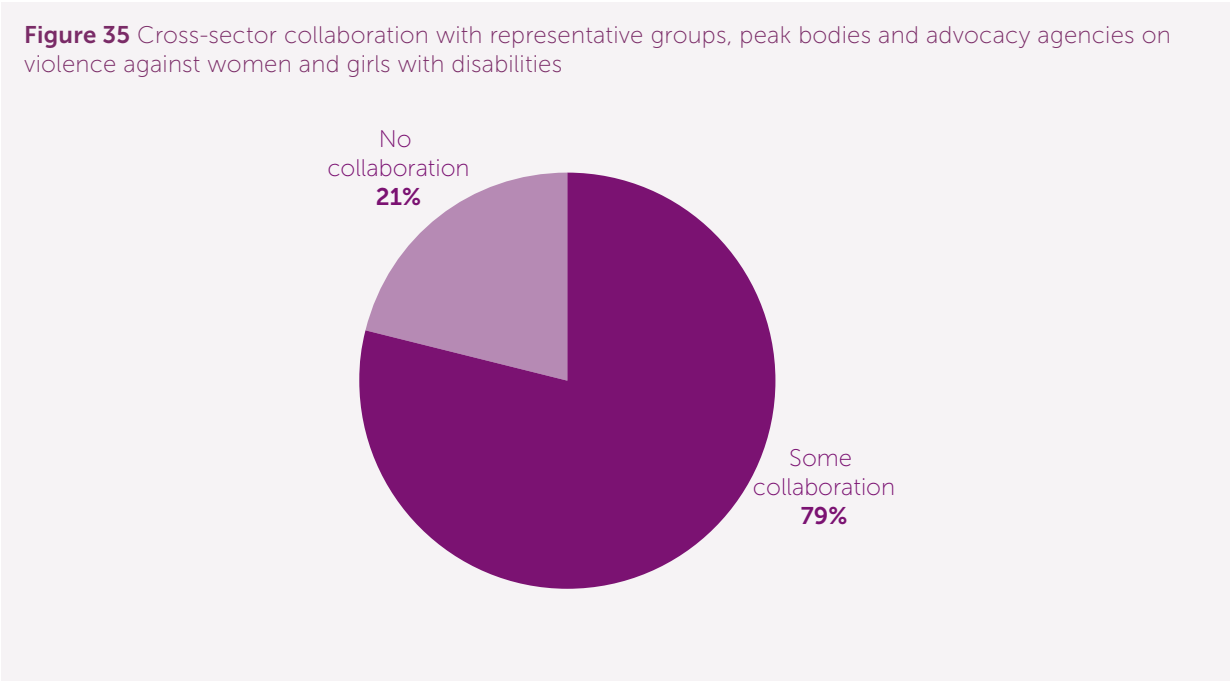
Collaboration between policy development agencies and representative groups, peak bodies and advocacy agencies occurs to a lesser extent (79%) outside of any formal partnership agreement or legislative framework (see Figure 35).

**Figure 34** Cross-agency collaboration on violence against women and girls with disabilities

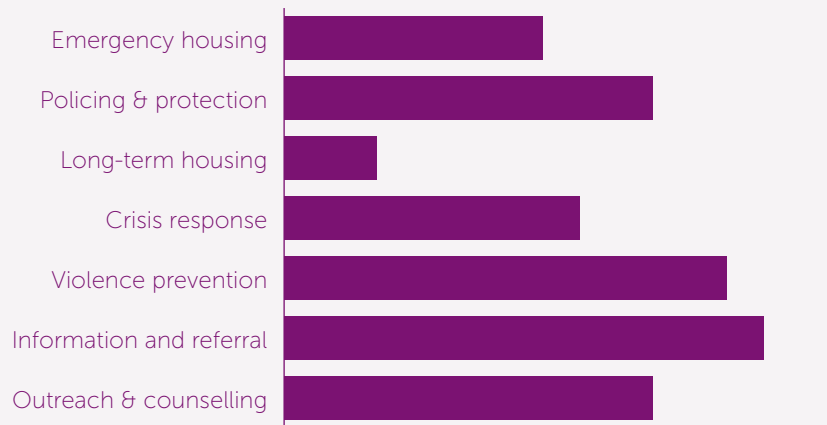


Where cross-agency and cross-sector collaboration does occur, it is usually around the provision of information, referral, outreach and counselling services, as Figures 36 and 37 indicate. A large part of what policy agencies reported as collaboration involved the

development and use of referral pathways. More direct or interventionary response services such as emergency housing, long-term housing, crisis response, and policing and protection do not appear to be a large focus of inter-agency or cross-sector collaboration.



**Figure 37** Level of cross-sector collaboration with representative groups, peak bodies and advocacy agencies on issues of violence against women with disabilities



A small number of policy agencies provided successful examples of cross-sector collaboration aimed at improving operational policies at service provider level. The Disability Services Commission in Western Australia, for example, in partnership with disability services, peak bodies and family members, developed a voluntary Code of Practice for the Elimination of Restrictive Practices, which offers a set of practice guidelines consistent with that state's Disability Service Standards.

There is widespread recognition of the need for a whole-of-government approach to preventing and ending violence against women and girls. Similarly, while most departments do not develop policy specifically on or for WGWD, there is awareness across most departments of the high proportion of WGWD in their target cohort and the disability-related issues within their remit. It is assumed that disability issues are addressed through a range of human service and welfare programs to which everyone, including women and girls with disabilities, are entitled. The specific issue of violence against women and girls with disabilities, however, is not reflected in current cross-departmental policy activities. As this research shows, few departments or agencies are responsible for policy that brings disability issues together with the issue of violence against women,

recognising that gender and disability interact in ways that affect both the rate and the nature of violence perpetrated.

Both service providers and representative organisations identified that one of the key barriers to developing a sustainable collaborative framework across the various related policy portfolios of relevance to the issue is the siloing of resources, expertise and responsibility. Many of the respondents suggested that that this was perpetuated by the lack of inter-departmental and cross-sectoral collaboration, as governments lacked an understanding of gender and how gender impacts upon the different relationships that women and girls with disabilities are involved in. For example, service and representative organisations stated that on numerous occasions departmental officials were made aware of the issue, however, the issue was referred on to another department as it was not considered to be within the mandate of the original department approached.

Policy makers largely agreed with these findings, stating that there was a need for improved and better collaboration between the relevant government agencies and stakeholders to enable better responses. Although some disability departments may have in place appropriate policies to guide staff, some



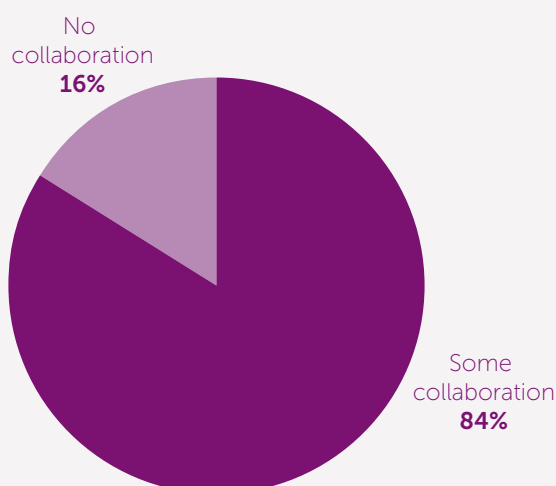
policy makers felt that there was a need for increased sensitisation of service providers on issues relating to violence against women and girls with disabilities to enable a better service response as part of an inter-sector collaboration initiative.

### 5.2.3 REPRESENTATIVE ORGANISATION COLLABORATION

Of the twenty five representative organisations that provided information on the nature of their collaboration, eighty-four per cent reported some level of collaboration with organisations from other sectors, as Figure 38 indicates. Cross-sector collaboration occurs mainly with information and referral, legal, and domestic violence and sexual assault services. It appears that the role of these services is to secure representation for women and girls with disabilities experiencing or at risk of violence through advocacy agencies, rather than to refer them directly to front-line services. Indeed, representative organisations reported less collaboration with front-line services such as housing/homelessness, health, mental health and disability services.

Service providers and representative organisations all suggested that one of the key strategies to strengthen cross-sector collaboration should include opportunities for cross sector information sharing and networking and in particular, via the policy process. Service providers and representative organisations agreed that many of the siloing effects of government policy could be overcome if government agencies readily involved services in the policy making environment. Some service providers stated that input into the process of policy making through direct advocacy and lobbying or via consultations and liaison with government departments or via peak bodies would overcome some of the existing barriers to collaboration. Some representative organisations suggested that input through cabinet processes or through committee memberships and participation in relevant task forces and steering committees was a useful collaborative process. Others suggested that advocating through area specific reporting networks such as Communities of Practice where also necessary to building long term collaborative networks.

**Figure 38** Inter-sector collaboration on violence against women and girls with disabilities



### 5.3 SUMMARY IMPLICATIONS

- Survey responses across all stakeholder groups strongly suggest the critical need to develop an effective framework to build, implement and support cross-sectoral collaboration to appropriately address the needs of women and girls with disabilities who are experiencing or are at risk of violence. This will require professionals working in all relevant sectors to build their awareness of and relationships with services operating in other sectors. As noted in Theme 2: Responding to Violence, women and girls with disabilities experiencing both overt and covert forms of violence are being referred on to other services for support. However, this has not guaranteed a *pathway to safety* for this group. All respondent groups felt that the absence of a formal framework for collaboration was one key reason that women and girls with disabilities are referred multiple times to various alternative services without necessarily ever receiving the required service.

- This process of constant and revolving referral without an ultimate destination service is largely due to services maintaining a narrow definition of either:
  - a) category of service user group within their organisational mandate which stems from the broader policy framework in which they work; or
  - b) the type of service that they are providing, that is, a disability service, a violence information service, etc.

Thus, to ensure sustainable development of appropriate responses to violence and greater awareness and prevention strategies it is essential to bring together the diverse services and policy groups critical to ensuring the women and girls with disability a *pathway to safety*.

- The survey responses across all stakeholder groups suggest that cross-sectoral collaboration is essential to bring together the diverse needs of the individual women to ensure that she is on a pathway to safety. Women and girls with disabilities experiencing or at risk of violence require a range of services such as trauma care and counselling, safe housing, access to justice, etc. This implies that all these services need to collaborate with each other in order to ensure the client's safety and needs.

## THEME 6 DATA CAPTURE AND USE

### 6.1 CONTEXT

The survey investigates the types of data collected and used to inform policy development in the areas of gender, disability and violence service delivery and prevention. The lack of available data to capture the extent of the problem has been one of the important areas identified in the literature if the problem of violence against women and girls with disabilities is to be tackled in an effective way. Lack of access to data already captured continues to impeded planning, design and implementation of services that address the specific needs of women and girls with disabilities who are experiencing or at risk of violence.

### 6.2 EVIDENCE

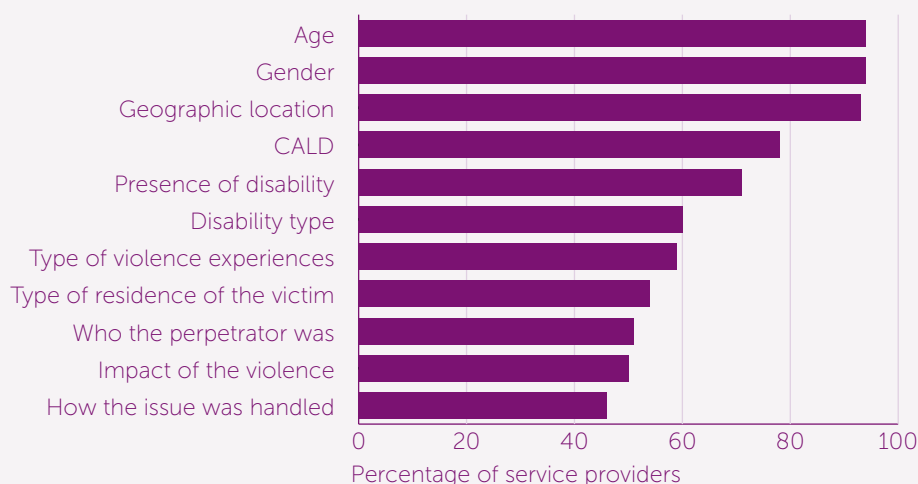
#### 6.2.1 SERVICE LEVEL DATA CAPTURE

In relation to the generation and utilisation of data, 143 service provider organisations

provided information regarding their practices in capturing and using data within and beyond their service contexts. Both disability and violence services appear to routinely record data about their service users although the extent and content of the information they collect has considerable variability, as shown in Figure 39.

Of the 56 violence service providers who provided information on their data collection procedures, over 95 per cent recorded data on the age, gender and geographic location of service users. However, less than two thirds of violence services record the presence of disability or disability type. Disability services appear to collect similar basic demographic data on their service users, however, less than half (16) of disability providers in the survey sample indicated that they collected data on their female clients experiencing or at risk of violence. When an incident of violence is disclosed by a woman or girl with disabilities, only 51 per cent record the type of violence experienced and only 40 per cent record its impact. In this instance less than a third (11) of the disability services surveyed record the relationship of the victim to the perpetrator, despite the widespread concern around intimate partner violence.

**Figure 39** Data collected by service providers



Some service providers recognised the need to capture information on incidence of violence and reporting of such incidence in a coordinated way as necessary to increase the capacity of service provision for women and girls with disabilities. In incidents where violence is reported, some service providers identified that they kept case notes and written reports, including conversations with guardians and carers. Others such as those in the legal area, keep case notes on conversations which are lodged in the service as a way of documenting evidence. Others indicated that they monitored and collected service level indicators which they reported to the appropriate government authority. Of concern is that there is no specific data from government child protection agencies on the prevalence of children, let alone girls, with disabilities who come to their attention.

### 6.2.2 SERVICE LEVEL DATA USE

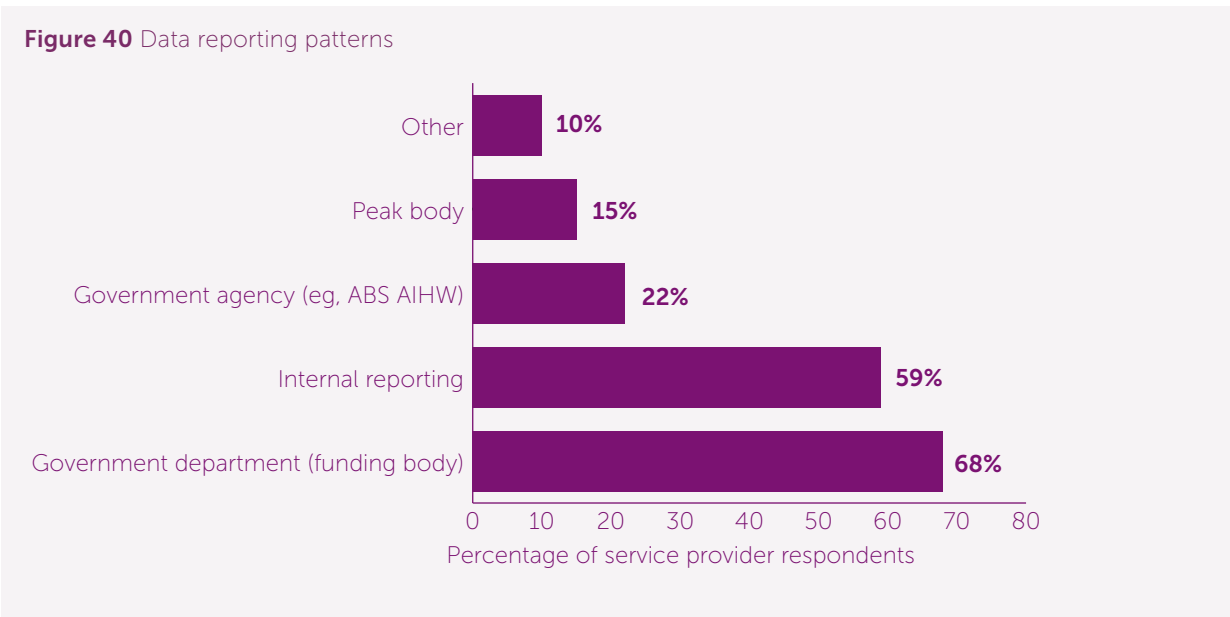
As Figure 40 indicates, the majority (68%) of service providers report service user data to the government department/s from which they receive funding. Fifty-nine per cent of service providers collect data on violence against women and girls internally, yet less than a

quarter report this data externally to agencies such as the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) as part of their contracted reporting requirements.

#### QUESTION TO WHOM DO YOU REPORT DATA ON WOMEN AND GIRLS WITH DISABILITIES EXPERIENCING OR AT RISK OF VIOLENCE

Some service providers suggested that they recorded case level information which was shared on referral while others identified mandatory reporting requirements.

Availability of data in the form of client feedback was inconsistent and where available was utilised in varying ways across service provider respondents. While some service providers identified that they did not have mechanisms for collecting feedback, others identified that even though the information is collated, it is rarely used. Others utilise this data to feed into service review and planning process and for the development of policies and procedures to enhance service delivery options. Others identified the use of service feedback data for law and policy reform submissions as well as



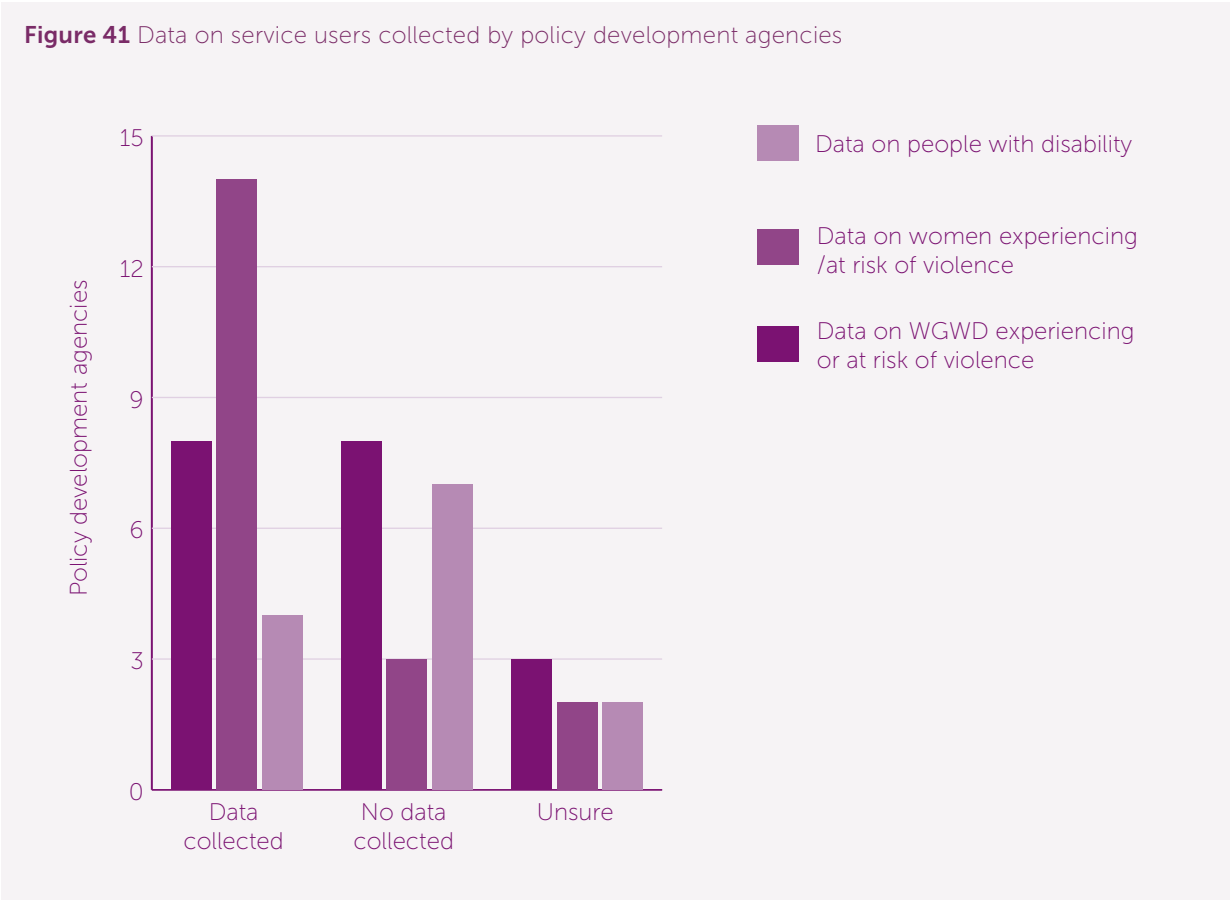
for systems advocacy and to support specific interventions to reduce violence against women and girls with disabilities.

No service providers reported that they had specific performance evaluations targeted for women and girls with disabilities. Although client satisfaction surveys were carried out, they are not specifically aimed at people with disabilities. Some service providers suggested that they are unable to evaluate their services due to lack of funding and insufficient resources. Others suggested that they evaluated feedback forms from randomly selected clients for planning purposes.

Overall lack of information sharing and siloing of information by each sector or service provider was recognised as a problem in service provision for women and girls with disabilities. On a positive note data collection and standard government reporting procedures have also provided some service providers opportunities to input into the policy making process.

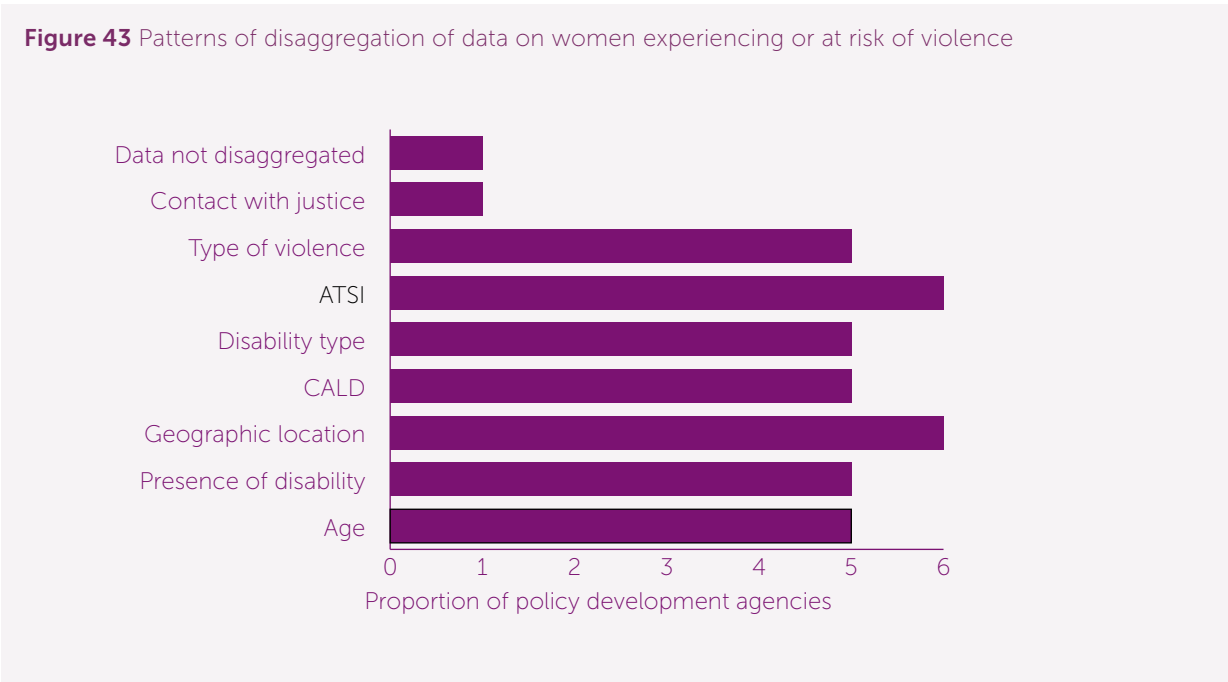
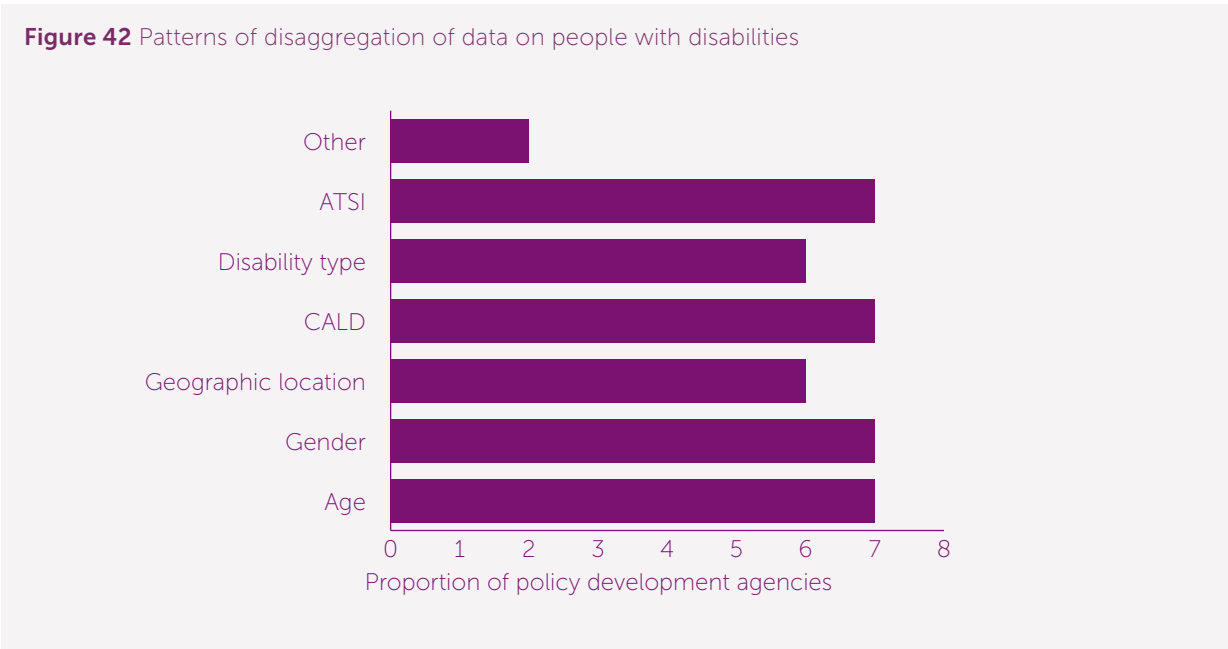
6.2.3 POLICY LEVEL DATA CAPTURE

Findings suggest that at the policy level, data on women experiencing or at risk of violence is collected at almost twice the rate (74%) of data on people with disabilities (42%), as shown in Figure 41.



As indicated by survey respondents responsible for policy development, data on people with disabilities collected for policy purposes is disaggregated by age, gender, aboriginality, and cultural/linguistic background, and less commonly by geographic location or disability

type, as shown in Figure 42. In relation to women and girls experiencing or at risk of violence, Figure 43 shows that while similar demographic data is collected, the presence of disability and disability type is recorded by only 5





#### 6.2.4 POLICY LEVEL DATA USE

Most agencies were able to identify the policies and legislative requirements that govern the collection of data on people with disabilities including State/Territory-level disability action plans, community services acts, and health information standards, as well as federal-level policies such as the National Disability Agreement 2009, the National Plan to Reduce Violence against Women 2010-2022, the Sex Discrimination Act 1984, and the National Partnership Agreement on Homelessness. However only a small number of policy development agencies (2) were able to describe how these demographic data are used as evidence of the level and types of need across different communities for the strategic planning of targeted services. So it appears that agencies are aware of why they need to capture data but have limited understanding or knowledge of its potential or actual uses.

Data on violence against women and girls for policy development appears to be collected and used in an uncoordinated and ad hoc manner. Few agencies were aware of the requirements or general purpose of data collection regulations with only two being able to describe how data are used to inform models of service delivery for women and girls experiencing or at risk of violence. One agency, however, reflected good practice in this area by using overall numbers of applicants for victims of crime assistance programs as an indicator of the level of stakeholder training required. This agency also interpreted low numbers of applicants to prompt community awareness and stakeholder engagement activities to ensure that victims of violence personal crime are aware of their rights. Another agency based in regional NT reported using this data to improve crisis

response systems for high-risk women and children and to ensure that male perpetrators are encapsulated in responses and supported to change their violent behaviours.

Policy agencies from both the disability and violence sectors cited privacy and information protection legislation as one factor that limits their capacity to collect and use service user data for policy development and program modelling.

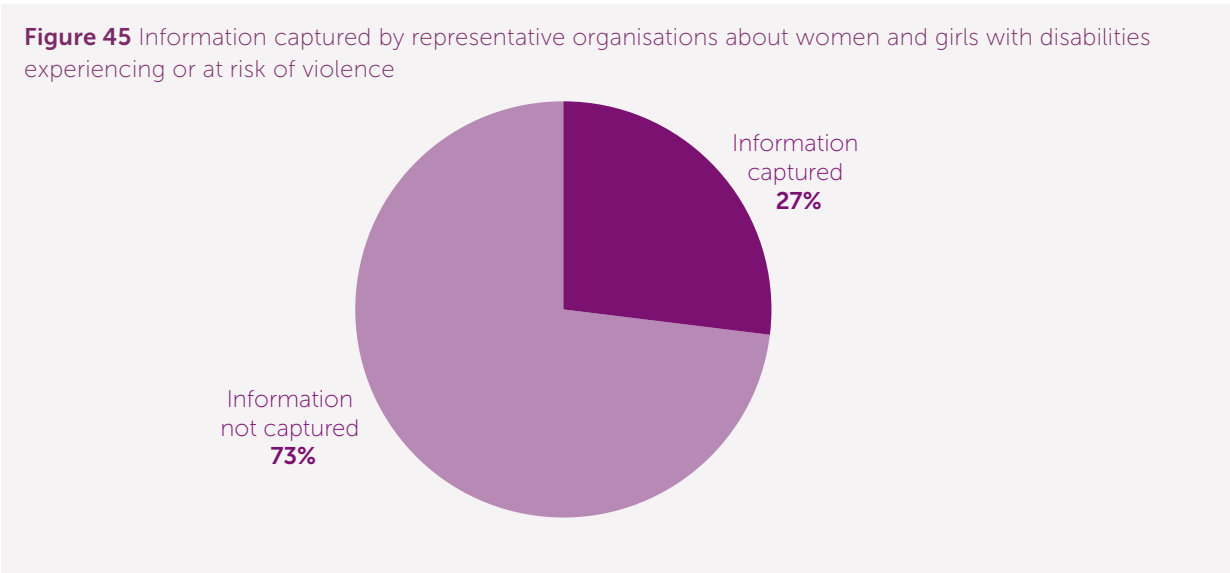
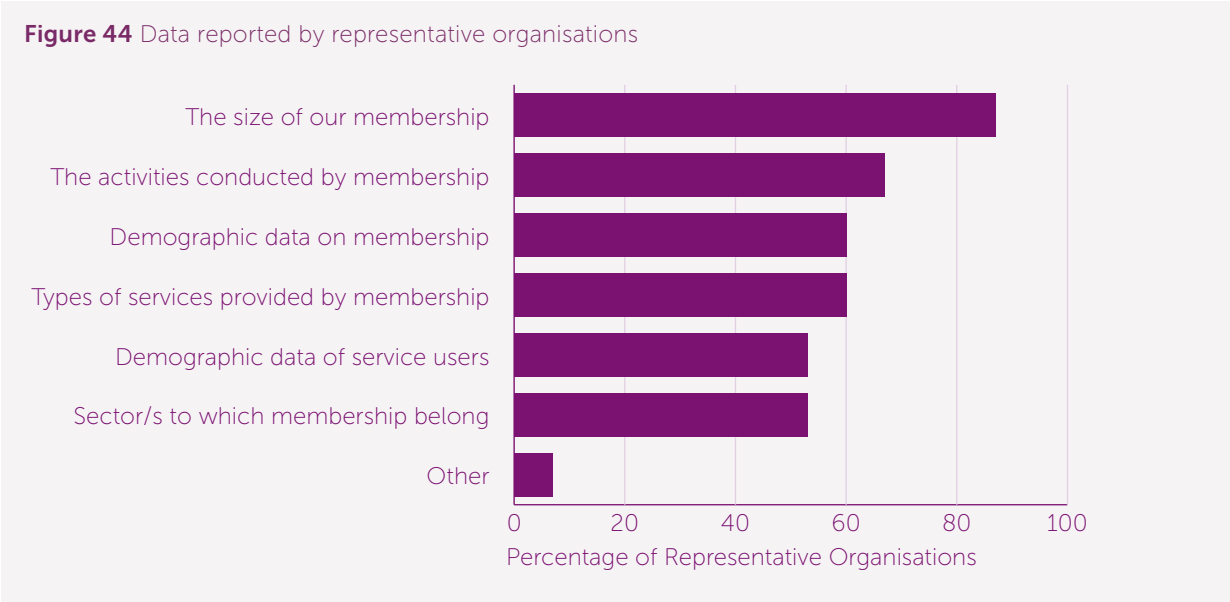
Of the nine policy development agencies that provided information on their data collection procedures, only two collect data specifically on women and girls with disabilities experiencing or at risk of violence. These data are not transmitted through any formal mechanisms such as the Disability Services, Juvenile Justice, or Mental Health Establishments Minimum Data Sets. However, health services, particularly emergency services, do transmit data on violence and abuse through The Specialist Homelessness Services National Minimum Data Set. Policy agencies commonly rely on internal service provider reporting because there are no policy frameworks or legislative instruments in place to capture data at this level of detail. When data on violence against women and girls with disabilities are captured, they are usually only utilised to indicate performance levels and direct future funding arrangements. In this case, a coordinated and legislated system of data collection is required to inform models of service delivery that address the specific needs of women and girls with disabilities experiencing or at risk of violence.

### 6.2.5 REPRESENTATIVE ORGANISATION DATA CAPTURE AND USE

Sixty-two per cent (15) of the representative organisations surveyed collect demographic information about their membership, as Figure 6.6 indicates. For most organisations, this includes data about the size of membership (87%), the activities members are engaged in (67%), demographic data on membership (60%), and the services the membership provides (if service providers) (60%). Demographic data on service users and information about the sector to which

the membership belongs (if service providers) is collected by 53 and 33 per cent of organisations respectively, as indicated by Figure 44.

Of concern is that less than a third of representative groups reported capturing any information about women and girls with disabilities experiencing or at risk of violence, as shown in Figure 45. Data that are captured are usually not shared, making it difficult for representative organisations to lobby effectively for women and girl victims with disabilities.



---

**QUESTION** DOES THE DATA YOU COLLECT FROM OR REPORT ON YOUR MEMBERSHIP CAPTURE INFORMATION ABOUT WOMEN AND GIRLS WITH DISABILITIES EXPERIENCING OR AT RISK OF VIOLENCE?

---

### 6.3 IMPLICATIONS

- It appears that the survey sample group has limited recognition of the importance of data capture as a means to critically understand issues of violence for this population group. This is despite multiple requirements for collection such as part of *The National Disability Strategy 2010-2020* as well as Australia's obligations under international human rights treaties more specifically in relation to the issue of violence against women and girls with disabilities.
- It appears that all respondent groups rarely considered or used the data they collect to inform the conceptualisation and design of legislation, policies and services in relation to this specific issue, and more generally. Many service organisations saw data capture for funding bodies, such as key government bodies, as a compliance and surveillance issue, rather than an opportunity to critically evaluate service provision standards, practices and outcomes for the service user group for whom they were designed.
- Despite the breadth of data collected by stakeholder groups, it appears that there is limited understanding and utilisation of
  - a) its potential importance;
  - b) how the data could be used to inform, improve or design services that are responsive to specific needs exhibited by this population group; and/or
  - c) inform front line practices to further front line sector capacity within the area.
- An area of confusion appears to be varied and multiple data collection processes that services are involved in which do not appear to communicate clearly nor effectively about the purpose and intent of the data collection process. As a result, services are unable to identify:
  - a) the relationship between the different data collection mechanisms in operation to which they are required to participate; and
  - b) how these differing mechanisms impact upon broader issues of governance, such as within the NDS, National Disability Agreement (NDA), etc.
- Effective data collection strategies are needed to ensure that services are not over-burdened by multiple contractual reporting requirements. Such strategies should aim to encourage service providers to actively engage in the collection and use of policy-relevant data, as well as responsive innovations across varying layers of government.
- Additionally, these strategies should be supported by a process whereby funding bodies undertake analysis of the data, report and feedback to services in a manner that can inform their organisational structures, delivery and practices for future effective delivery.

## REFERENCES

Australian Bureau of Statistics (ABS) (2003) *Disability, Ageing and Carers: Summary of findings*, Australian Bureau of Statistics, Canberra, Cat. No. 4430.0.

Australian Bureau of Statistics (ABS) (2006) *Personal Safety Survey Australia 2005*. Australian Bureau of Statistics, Canberra, (Re-issue) Cat. No. 4906.0.

Australian Bureau of Statistics (ABS) (2010) *Disability, Ageing and Carers, Australia: Summary of Findings, 2009*, Australian Bureau of Statistics, Canberra, Cat. No. 4430.0.

Australian Bureau of Statistics (ABS) (2011) Disability rates in decline: state and territory data now available. *Media Release, 1 March 2011*, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics (ABS) (2012) *Australian Social Trends June 201: Children with a disability*, Australian Bureau of Statistics, Canberra, Cat. No. 4102.0.

Australian Council of Social Service (ACOSS) (2013) *Poverty in Australia* (updated March 2013), ACOSS Paper 194.

Australian Domestic & Family Violence Clearinghouse (ADFVC) (2013) *Policy and Legislation*. Available at: [http://www.austdvclearinghouse.unsw.edu.au/au\\_resources.html](http://www.austdvclearinghouse.unsw.edu.au/au_resources.html).

Australian Human Rights Commission (AHRC) (2005) *National Inquiry into Employment and Disability: Issue Paper 1*. Australian Human Rights Commission.

Australian Human Rights Commission (AHRC) (2012a) *Australian study tour report: Visit of the UN Special Rapporteur on Violence against Women, 10-12 April 2012*. Australian Human Rights Commission.

Australian Human Rights Commission (AHRC) (2012b) *Independent Interim Report on CEDAW*. Australian Human Rights Commission.

Australian Institute of Health and Welfare (AIHW) (2008) *Disability in Australia: trends in prevalence, education, employment and community living*. Bulletin 61, June 2008. Canberra.

Australian Law Reform Commission (ALRC) (2010) *Family Violence – A National Legal Response*. ALRC Final Report 114. Available at: <http://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>.

Australian Law Reform Commission (ALRC) (2012) *Family Violence and Commonwealth Laws – People with Disability*. Available at: <http://www.alrc.gov.au/CFV-disability>.

Australian Productivity Commission (APC) (2004) *Review of the Disability Discrimination Act 1992*, Report No. 30, Melbourne.

Baldry, E., Dowse, L. and Clarence, M. (2012) *People with intellectual and other cognitive disability in the criminal justice system*. Sydney: Family & Community Services: Ageing, Disability & Home Care.

Baldry, E., McComish, C. and Clarence, M. (2009) *Punishing the vulnerable: Women with mental health disorders & cognitive disabilities in the NSW criminal justice system*. Presentation at Sisters Inside Conference, Brisbane.

Bartels, L. (2010) Emerging issues in domestic/family violence research. Research in Practice Report No.10. Criminology Research Council. Available at: <http://www.aic.gov.au/publications/current%20series/rip/1-10/10.html>.

Broderick, E. (2012) *Violence against women with a disability in rural Australia*. Speech at the Side Event of the 56th Session of the CSW-Rural Women and Girls with Disabilities: Economic Empowerment and Political Participation, 28 February 2012. United Nations, New York.

Brownridge, D. A. (2006) Partner violence against women with disabilities. Prevalence, risks and explanations. *Violence Against Women*, Vol. 12, No.9, pp. 805-822.

Community Affairs Legislation Committee (CALC) (2013) *National Disability Insurance Scheme Bill 2012* [Provisions].

Carlson, B. (1997) Mental Retardation and Domestic Violence: An Ecological Approach to Intervention, *Social Work* 42(1): 79-89.

Castelino, T. & C. C. Whitzman (2008) The Rhetoric and Reality of Preventing Family Violence at the Local Government Level. *Journal of Family Studies*, Vol. 14, No. 2-3, pp. 310-321.

Cattalini, H. (1993) *Access to services for women with disabilities who are subjected to violence*. Canberra: Australian Government Printing Service.

Committee on Economic, Social and Cultural Rights (CESCR) (2009) *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Australia*, 12 June 2009, UN Doc. E/C.12/AUS/CO/4.

Committee on the Elimination of Discrimination against Women (CEDAW) (2010) *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*. Document No. CEDAW/C/AUS/CO/7, 30 July 2010, United Nations.

Committee on the Elimination of Discrimination against Women (CEDAW) (2012) *Concluding observations on the combined sixth and seventh periodic reports of Australia, adopted by the Committee at its forty-sixth session (12-30 July 2010)*. Addendum: Information provided by Australia on the follow-up to the concluding observations of the Committee. Document No. CEDAW/C/AUL/CO/7/Add.1:22 November 2012, United Nations.

Chenoweth, L. (1997) *Violence and women with disabilities: silence and paradox* in Cook, S. & J. Bessant *Women's Encounters: Australian Experiences*. Thousand Oaks, California: Sage Publications.

Chenoweth, L. & S. Cook (2001) *Violence Against Women: Guest Editors' Introduction*. *Violence Against Women*, Vol. 7, No. 4, pp. 363-366.

Chisholm, R. (2009) *Family Courts Violence Review*. Available at: <http://indigenousjustice.gov.au/db/publications/284248.html>.

Cockram, J. (2003) *Silent voices: Women with Disabilities and Family and Domestic Violence*. Western Australia: People with Disabilities (WA) Inc. Available at: <http://www.wvda.org.au/silent4.htm>.

Collins, J. (2013) *The Elimination and Prevention of All Forms of Violence Against Women and Girls: Statement delivered at the 57th Session of the Commission on Status of Women*, 5 March 2013. United Nations, New York.

Commonwealth of Australia (2009a) *A Snapshot to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*. The National Council to Reduce Violence against Women and their Children.

Commonwealth of Australia (2009b) *The Costs of Violence against Women and their Children. The National Council to Reduce Violence against Women and their Children*, Canberra.

Commonwealth of Australia (2010) *National Plan to Reduce Violence against Women and their Children 2010-2022*. Council of Australian Governments.

Commonwealth of Australia (2011a) *Family Violence and Commonwealth Laws - Improving Legal Frameworks, Final Report*. The Australian Law Reform Commission.

Commonwealth of Australia (2011b) *Disability Care and Support: Productivity Commission Inquiry Report*. Overview and Recommendations, Report No. 54. Productivity Commission.

Corker, M. & T. Shakespeare (Eds.) (2002) *Mapping the Terrain in Disability/Postmodernity: Embodying disability theory*. London: Continuum.

Center for Research on Women with Disabilities (CROWD) (2009). *Violence against women with physical disabilities: Final report submitted to the Centers for Disease Control and Prevention* (Award Reference NO. R04=CCR614142). Houston, TX: Baylor College of Medicine, Department of Physical Medicine and Rehabilitation. Available at: <http://www.bcm.edu/crowd>.

Commission on the Status of Women (CSW) (2013) *Short History of the Commission on the Status of Women*. United Nations. Available at: <http://www.un.org/womenwatch/daw/csw/index.html#output>.

Disability Representative, Advocacy, Legal and Human Rights Organisations (DRALHRO) (2012) *Disability Rights Now: Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities*.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) (2009) Background paper to Time for Action: The National Council's plan to reduce violence against women and children, 2009–2021. FaHCSIA, Canberra. Available at: <http://www.fahcsia.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/background-paper-to-time-for-action-the-national-councils-plan-for-australia-to-reduce-violence-against-women-and-their-children?HTML>.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) (2012) *Standard Funding Agreement with WWDA*.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) (2013) *Foundation to Prevent Violence against Women and their Children*. Available at: <http://www.fahcsia.gov.au/our-responsibilities/women/programs-services/reducing-violence/foundation-to-prevent-violence-against-women-and-their-children>.

Dillon, J. (2010) *Violence against people with cognitive impairments. Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria*. Melbourne: Office of the Public Advocate

Dowse, L., Baldry, E. and Snoyman, P. (2009) Disabling criminology: Conceptualising the intersections of critical disability studies and critical criminology for people with mental health and cognitive disabilities in the criminal justice system. *Australian Journal of Human Rights* 15 (1): 29-46.

Dowse, L., Frohmader, C. & Meekosha, H. (2010) Intersectionality: Disabled Women, Chapter 14 in P. Eastaugh (ed), *Women and the Law in Australia*, LexisNexis: Sydney.

Finkelstein, V. (1993) Disability: A social challenge or an administrative responsibility? In Finkelstein, V., S. French & M. Oliver (eds) *Disabling Barriers – Enabling Environments*. London: Open University Press/Sage.

Fitzsimons, N. M. (2009) Combating Violence and Abuse of People with Disabilities: A Call to Action. *Sexuality and Disability*, Vol. 27, No. 4, pp. 249-250.

Flood, M. (2006) *Violence Against Women and Men in Australia: What the Personal Safety Survey can and can't tell us*. DVIRC Quarterly, Edition 4, Summer 2006. Domestic Violence and Incest Resource Centre (DVIRC), Victoria.

Frohmader, C. & H. Meekosha (2012) Recognition, respect and Rights: Women with Disabilities in a Globalised World, Chapter 18 in Goodley, D., B. Hughes & L. Davis *Disability and Social Theory: New Developments and Directions*. Basingstoke: Palgrave Macmillan.

Frohmader, C. & Swift, K. (2012) Opening minds & opening doors: Re-conceptualising 'domestic violence' to be inclusive of women with disabilities in institutions. *CDFVRe@der*, Vol. 11, No. 2, pp. 7-8. Available at: <http://www.noviolence.com.au/public/reader/readerdec2012.pdf>.

Hague, G. & L. Sardinha (2010) Violence against Women: Devastating Legacy and Transforming Services. *Psychiatry, Psychology and Law*, Vol. 17, No. 4, pp. 503-522.

Hague, G., R. Thiara & A. Mullender (2011) Disabled Women and Domestic Violence: Making the Links, a National UK Study. *Psychiatry, Psychology and Law*, Vol. 18, No. 1, pp. 117-136.

Healey, L., Howe, K., Humphreys, C., Jennings, C. & F. Julian (2008) *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. Victorian Women with Disabilities Network Advocacy Information Service, Melbourne.

Healey, L., Humphreys, C. & Howe, K. (2013) Inclusive Domestic Violence Standards: Strategies to Improve Interventions for Women With Disabilities? *Violence and Victims*, Vol. 28, No. 1, pp. 50-68.

Howe, K. (1999) Violence against women with disabilities – an overview of the literature, *Women Against Violence*, Issue 7, December 1999, pp. 11-19.

Human Rights Council (HRC) (2011) *Report of the Office of the United Nations High Commissioner for Human Rights on good practices in efforts aimed at preventing violence against women*. A/HRC/17/23. United Nations, Geneva.

Human Rights Council (HRC) (2011b) *Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo*. A/HRC/17/26. United Nations, Geneva.

International Network of Women with Disabilities (INWWD) (2011) *Violence Against Women with Disabilities*. Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities, Center for Women Policy Studies.

International Network of Women with Disabilities (INWWD) (2013) *Interdependence: including women with disabilities in the agenda of the women's movement – our fears, realities, hopes and dreams*. Submission by Myra Kovary, Coordinator of INWWD, to the Half-Day of General Discussion on Women and Girls with Disabilities at the 9th Session of the UNCRPD on 17 April 2013. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGD17April2013.aspx>.

Lord, J. E., K. N. Guernsey, J. M. Balfe & V. L. Karr (2007) *Action and Advocacy on the Rights of Persons with Disabilities*. University of Minnesota Human Rights Resource Centre.

Lund, E. M. (2012) Violence against people with disabilities: New developments and important implications. *Spotlight on Disability Newsletter*, December 2012.

Meekosha, H. & L. Dowse (2007) Integrating critical disability studies into social work education and practice: An Australian perspective. *Practice* Vol. 19, No. 3, pp. 59-72.



Meekosha, H. & R. Shuttleworth (2009) What's so critical about critical disability studies. *Australian Journal of Human Rights*. Vol. 15, No. 1, pp. 47-75.

Mitchell, L. (2011) *Domestic Violence in Australia – An Overview*. Background Note. Department of Parliamentary Services, Canberra.

Mulder, L. (1995) *Reclaiming Our Rights: Access to existing policy, legal and support services for women with disabilities who are deaf or hearing impaired who are subjected to violence*. A Report to the Department of Women, NSW.

Mulroney, J. (2003) *Australian Statistics on Domestic Violence*. Australian Domestic and Family Violence Clearinghouse Topic Paper. Sydney NSW.

National Disability Strategy Implementation Reference Group (NDSIRG) (2012) *Report to the Council of Australian Governments 2012*. FaHCSIA.

Nguyen, X. T. (2012) *Global Thematic Consultation on Addressing Inequalities: Persons with Disabilities*. Online Discussion Synopsis, UNICEF.

Office of the High Commissioner for Human Rights (OHCHR) (2010). *Monitoring the Convention on the Rights of Persons with Disabilities: Guidance for Human Rights Monitors*. United Nations, Geneva and New York.

Oliver, M. (1990) *The Politics of Disablement*. London: Macmillan.

Oliver, M. (1983) *Social Work with Disabled People*. Basingstoke: Macmillans.

Ortoleva, S. & H. Lewis (2012) *Forgotten Sisters – A Report on Violence against Women with Disabilities: An Overview of its Nature, Scope, Causes and Consequences*. Northeastern Public Law and Theory Faculty Research Papers Series No. 104-2012. Northeastern University, Boston, USA.

Posselt, H. (2005) Measuring violence against women in Australia. *Statistical Journal of the United Nations*, ECE 22, pp. 239-253.

People with Disability Australia (PWDA) (2013) *Key figures about women and girl with disability*. Facts & figures – STVP. Available at: <http://www.stvp.org.au/stats.htm>.

Sobsey, D. (1994) *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?*. Baltimore: Paul H. Brookes Publishing Company.

Stathopoulos, M. (2012) *Addressing women's victimisation histories in custodial settings*. Melbourne: Australian Centre for the Study of Sexual Assault.

Stein, M. A. & P. J. S. Stein (2007) *Beyond Disability Civil Rights*. William & Mary Law School Research Paper No. 09-38. Hastings Law Journal, Vol. 58, pp. 1203-1240.

Swift, K. (2013) *Women with disabilities and violence: Challenges and visions in the Asia Pacific Region*. Presentation at the CSW57 Side Event, 8 March 2013, United Nations.

Thomas, C. (2004) Disability and impairment in Swain, J., S. French, C. Barnes & C. Thomas (eds.) *Disabling barriers - Enabling environments*. London: Sage.

United Nations (1993) *Declaration on the Elimination of all forms Violence against Women*. Available at: <http://www.un.org/documents/ga/res/48/a48r104.htm>.

United Nations (2006) *Integration of the human rights of women and the gender perspective: The Due Diligence Standard as a tool for the elimination of violence against women*. Report of the Special Rapporteur on Violence against Women (E/CN.4/2006/61). United Nations, New York.

United Nations Population Fund (UNFPA) (2005) *State of World Population 2005: The Promise of Equality - Gender Equity, Reproductive Health and the Millennium Development Goals*. UNFPA, New York.

United Nations General Assembly (UNGA) (2012) *Accelerating Progress towards the Millennium Development Goals: Options for Sustained and Inclusive Growth and Issues for Advancing the United Nations Development Agenda beyond 2015*. Annual Report of the Secretary-General. UN. Doc. No. A/67/257.

UN Women (2011) *Developing Legislation on Violence against Women and Girls, Handbook*. Available at: <http://www.endvawnow.org/en/modules/view/8-legislation.html>.

VicHealth (2011) *Preventing violence against women in Australia: Research summary*. Victorian Health Promotion Foundation. Available at: <http://www.vichealth.vic.gov.au>.

Women's Health (2011) *Violence against women with disabilities*. US Department of Health and Human Services, Office on Women's Health. Available at: <http://www.womenshealth.gov/violence-against-women/types-of-violence/violence-against-women-with-disabilities.cfm>.

World Health Organisation (WHO) (2013) WHO report highlights violence against women as a 'global health problem of epidemic proportions'. *News Release*, 20 June 2013. Available at: [http://www.who.int/mediacentre/news/releases/2013/violence\\_against\\_women\\_20130620/en/](http://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/en/).

Women With Disabilities Australia (WWDA) (2004) *Submission to the South Australian Government's Discussion Paper: "Valuing South Australia's Women: Towards A Women's Safety Strategy For South Australia"*. Rosny Park, Tasmania: Women With Disabilities Australia.

Women With Disabilities Australia (WWDA) (2007) *Forgotten Sisters: A Global Review of Violence against Women with Disabilities*. Rosny Park, Tasmania: Women With Disabilities Australia.

Women With Disabilities Australia (WWDA) (2008) *WWDA Policy Paper: 'The Role of Advocacy in Advancing the Human Rights of Women with Disabilities in Australia'* (April). Rosny Park, Tasmania: Women With Disabilities Australia. Available at: <http://www.wwda.org.au/advpolpaper08.htm>.

Women With Disabilities Australia (WWDA) (2009) *Submission to the National Human Rights Consultation*. WWDA, Rosny Park, Tasmania. Available at: [www.wwda.org.au/subs2006.htm](http://www.wwda.org.au/subs2006.htm).

Women With Disabilities Australia (WWDA) (2010) *Assessing the Situation of Women with Disabilities in Australia: A Human Rights Approach*. Women With Disabilities Australia, Rosny Park, Tasmania. Available at: <http://www.wwda.org.au/subs2011.htm>.

Women With Disabilities Australia (WWDA) (2011) *Submission to the UN Analytical Study on Violence against Women and Girls with Disabilities*. Rosny Park, Tasmania, Australia.

Women With Disabilities Australia (WWDA) (2012) *Safety Taskforce Reform Project: Improving Service Delivery for Women with Disabilities – Project Proposal*. April 2012. Rosny Park, Tasmania: Women with Disabilities Australia.







Women  
With  
Disabilities  
Australia  
(WWDA)