Abuse Prevention Strategies in Specialist Disability Services

FINAL REPORT
Part 1: Framework for Improvement
Part 2: Review of Literature and Current Practice

Commissioned by National Disability Administrators on behalf of Commonwealth, State and Territory Ministers responsible for disability services in Australia.

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The Executive Summary of this report is also available as a separate document.

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Acknowledgments

All Commonwealth, State and Territory Programs participated in this project by providing detailed information regarding current practices in the administration of disability services and strategies in place to prevent abuse or neglect. The project was overseen by a Steering Committee with members from the following agencies:

- Commonwealth Department of Family and Community Services
- Department of Ageing, Disability and Home Care, New South Wales
- Department of Human Services, Victoria
- Disability Services Commission, Western Australia

In addition, a working party assisted the development of the final report. Members of the working party included representatives from the agencies listed above and the following agencies:

- Department of Health, Housing and Community Care, Australian Capital Territory
- Department of Human Services, Tasmania.

This project was undertaken on contract to the National Disability Administrators by Samantha Page, Peter Lane and Gavin Kempin from the Nucleus Group, for further information please visit:
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PROJECT OVERVIEW

In comparison to the general population, people with a disability are more likely to experience abuse, neglect and violence. The abuse experienced by people with a disability is also more likely to be severe in impact, to involve multiple incidents, to be sustained over a long period of time and to involve multiple perpetrators. The abuse of people with disabilities is a very complex issue that can be difficult to comprehend and analyse, with a multiplicity of inter-relating contributing factors.

The National Disability Administrators on behalf of Commonwealth, State and Territory Ministers responsible for disability services in Australia have undertaken this project to enhance quality and improve abuse prevention strategies in services funded under the Commonwealth/State Disability Agreement (CSDA).

The project began with a thorough review and critical analysis of research and practice in CSDA jurisdictions and comparable human service sectors in Australia and overseas. This analysis has informed the development of a set of key principles for an effective abuse prevention framework that may be tailored to best fit conditions across States and Territories, population and program types.

The final report is provided in two parts:

Part 1: Framework for Improvement

The Framework is founded upon the review of current practice and research; it contains key principles, mechanisms and examples of practice to assist effective abuse prevention.

Part 2: Review of Literature and Current Practice

The Review examines quality assurance and abuse prevention in human services, across Australian and international jurisdictions. The focus is on the provision of services for vulnerable adults and children. The review is structured to mirror the components of the Framework (Part 1) this allows cross-reference between the key principles in the framework and the content of the review.

This report is intended as a practical resource for CSDA Administrators in Commonwealth and State/Territory jurisdictions. The Framework is not intended to represent a prescriptive national approach. Rather, it is a resource that jurisdictions may draw on when developing knowledge and guidelines tailored to their local context.

The diversity across jurisdictions and service sectors with regard to population, community characteristics and the nature of services provided to people with a disability, requires a flexible approach to the development of specific strategies in service delivery and government policy.

THE FRAMEWORK

The *Framework for Improvement* is organised into five '*Components'* of equal importance for comprehensive and holistic abuse prevention. Each component contains a set of *'Key Principles'*, developed from the review of literature and current practice. The key principles provide a foundation for building effective abuse prevention into the operation of CSDA programs. To assist in application of the key principles, *'Mechanisms'* have been identified. The mechanisms include practical approaches that may be relevant to key principles across a number of components. *'Critical Success Factors'* have been identified for each mechanism and actual working *'Examples'* described with references for further follow up and study. These relationships are described in the figure below.

Figure 1: Framework for Improvement

SECTION A: COMPONENTS				
1. UNDERSTANDING ABUSE	2. PRIMARY PREVENTION	3. PREVENTING SYSTEMS ABUSE	4. SAFER SERVICE ENVIRONMENTS	5. RESPONDING TO ABUSE OR RISK
1.1 The Language of Abuse 1.2 Patterns of Abuse 1.3 Models of Abuse and Prevention 1.4 Incidence and Impact 1.5 Research and Analysis	2.1 Inclusive Communities 2.2 Advocacy 2.3 Building Individual Resilience 2.4 Family Supports and Intervention	3.1 Systems Development 3.2 Ensuring Quality 3.3 Service Monitoring 3.4 Consumer Empowerment 3.5 Increasing Professionalism	4.1 Organisation Change & Culture 4.2 Training & Managing Support Workers 4.3 Risk Assessment 4.4 Policies, Procedures & Codes 4.5 Behaviour Intervention Guidelines	5.1 Recognition & Reporting 5.2 Vulnerable Adult Protection 5.3 Coordinated Interagency Response 5.4 Supporting Victims 5.5 Criminal Justice Issues 5.6 Community-Based Crime Prevention

SECTION B: MECHANISMS				
SAFEGUARDS & RIGHTS	PARTICIPATION & COLLABORATION	SERVICE DELIVERY	AWARENESS & TRAINING	KNOWLEDGE SYSTEMS
▪ Acts and Regulations ▪ Probity Screening ▪ Independent Monitoring and Complaints Agencies ▪ Adult Protective Services	▪ Consumer Participation ▪ Cross-Sector Collaboration ▪ Cross-Government Collaboration	▪ Access and Coordination ▪ Quality Assurance ▪ Policy Resources and Guidelines	▪ People with a Disability ▪ Community Education ▪ Professional Development ▪ Professional Development in Related Sectors	▪ Defining and Describing Abuse ▪ Data Collection & Analysis ▪ Evaluation ▪ Development

EXAMPLES OF PRACTICE FROM AUSTRALIA AND OVERSEAS

The five components and forty-five key principles of the Framework for Abuse Prevention are summarised below.

FIGURE 2: KEY PRINCIPLES

FRAMEWORK COMPONENT	KEY PRINCIPLES
1. UNDERSTANDING ABUSE	
1.1 The Language of Abuse	1. Use consistent terminology.
	2. Describe abuse appropriately and fully.
1.2 Patterns of Abuse	3. Develop full understanding of what abuse is.
1.3 Models of Abuse and Prevention	4. Prevention efforts target the cultural, environmental and interpersonal causes of abuse.
1.4 Incidence and Impact	5. The incidence and impact of abuse is recognised.
1.5 Research and Analysis	6. The research and review of abuse is continual.
2. PRIMARY PREVENTION	
2.1 Inclusive Communities	7. Increase social integration and reduce segregation.
	8. Promote the valued status of people with a disability and raise awareness.
	9. Increase the socio-economic participation of people with a disability.
2.2 Advocacy	10. Advocates are accessible and effective for individuals, groups and populations of people with a disability within service systems.
2.3 Building Individual Resilience	11. Individual resilience to abuse is enhanced.
	12. Resources to build individual resilience are managed effectively.
2.4 Family Supports and Intervention	13. Use a range of strategies to support families and reduce family stress.
	14. Develop and resource responses to abuse in the family setting.
3. PREVENTING SYSTEMS ABUSE	
3.1 Systems Development	15. Approaches to improvement of disability service systems address abuse prevention.
3.2 Ensuring Quality	16. Service quality is assessed against benchmarks that are outcome focused, establish clear minimum standards and promote continuous improvement.
	17. Strong mechanisms ensure compliance with disability services legislation.
3.3 Service Monitoring	18. Monitoring of services is independent of the purchaser and provider.
3.4 Consumer Empowerment	19. Consumers are aware of their rights and able to exercise influence.
	20. Consumers are actively involved in quality assurance and service monitoring.
	21. Consumers have access to independent complaints mechanisms.
	22. Review of consumer complaints informs quality improvement.
3.5 Increasing Professionalism	23. Systems development and quality assurance raise professional standards in disability services.
	24. Probity screening protects vulnerable people within disability services from predatory offenders.

4. SAFER SERVICE ENVIRONMENTS	
4.1 Organisation Change & Culture	25. Workplace culture within service settings supports valued attitudes and continuous learning.
4.2 Training & Managing Support Workers	26. Staff in disability services have basic competencies in abuse prevention.
	27. Human resource planning includes monitoring indicators and risks related to abuse.
4.3 Risk Assessment	28. Individual risk assessment is included in individual support planning.
	29. Environment risk assessment informs service practice.
4.4 Policies, Procedures & Codes	30. Service management includes policies and procedures related to abuse.
	31. Policy guidelines related to abuse prevention are developed based on good practice and are evaluated.
4.5 Behaviour Intervention Guidelines	32. The use of intrusive behaviour intervention practices is prohibited without authorisation and if authorised it is restricted and monitored.
	33. Good practice in behaviour intervention is promoted and resourced.
5. RESPONDING TO ABUSE OR IDENTIFIED RISK	
5.1 Recognition & Reporting	34. The recognition and reporting of abuse and neglect is supported by clear procedures operating at individual, service agency and government jurisdiction levels.
5.2 Vulnerable Adult Protection	35. Provide effective protection for vulnerable adults.
	36. Consumers unable to make informed decisions and at risk of abuse, neglect or self-harm are appointed legal guardians.
	37. Protect anyone, who reports abuse or neglect, from retribution.
5.3 Coordinated Interagency Response	38. There is a coordinated interagency response to abuse and neglect.
5.4 Supporting Victims	39. Services that assist victims to escape and recover from abuse (including crisis and counselling services) are accessible to adults and children with a disability.
5.5 Criminal Justice Issues	40. Collaborate with the criminal justice system to provide access for people with a disability.
	41. Support services work locally with the criminal justice system to assist offenders who have a disability and reduce repeat offending.
5.6 Community-Based Crime Prevention	42. As far as possible and with respect to individual rights of disclosure, generic community service agencies (including the police, the health sector and victim support services) collect data on the abuse, neglect and crime against people with a disability.
ADDITIONAL CONSIDERATIONS FOR SPECIFIC GROUPS	
Aboriginal and Torres Strait Islander People	43. Preventing abuse is incorporated in the development of culturally appropriate services (generic and specific) for Aboriginal or Torres Strait Islander people with a disability.
People with Cultural and Linguistically diverse backgrounds	44. Quality assurance and abuse prevention approaches develop with consideration to cultural and linguistic diversity.
Children with a Disability	45. Disability and children's service sectors collaborate to protect children with a disability from abuse.

PART 1: FRAMEWORK FOR IMPROVEMENT

INTRODUCTION

This Framework has been developed by the National Disability Administrators on behalf of Commonwealth, State and Territory Minister's responsible for disability services in Australia. It is the culmination of a number of activities including:

- Analysis of Australian and international literature regarding abuse prevention in human services, particularly with regard to the provision of services to vulnerable adults and children.
- Research and compilation of a national summary of quality assurance processes and abuse prevention strategies in place in CSDA-funded services across all Australian Jurisdictions.
- Consultation with Commonwealth and State/Territory government agency representatives administering disability support services, aged care and services to people with a mental illness.

The Framework builds on current practice and research, deriving key principles and suggested mechanisms for effective abuse prevention. The Framework is intended to represent a practical tool that can be used as a resource by program administrators and service providers to tailor approaches to abuse prevention suited to their local contexts and circumstances.

HOW TO USE THIS DOCUMENT

Section A, Framework Components, contains the **key principles** (KP) for a comprehensive approach to abuse prevention within CSDA jurisdictions. There are five major components and one additional component containing principles relevant to specific groups such as children who have a disability. At the end of each component the key principles are summarised and linked to mechanisms that support their implementation.

Section B, Mechanisms, contains information related to mechanisms that allow the implementation of key principles. Critical success factors have been identified for the mechanisms and references are provided for comparison to examples of practice.

Complementing the Framework is a comprehensive review of literature and current practice in abuse prevention and quality assurance relevant to the disability services sector in Australia (Part 2 of this report). For each component in the Framework, more detailed information is provided in the review; this information appears under the same headings and in the same order as it is presented in the Framework for easy cross-reference. The review contains **Examples** of Practice that are referred to in Section A and B of the Framework. The Examples are numbered and an index is provided in the table of contents containing page references.

BACKGROUND

Abuse In The Lives Of People With A Disability

In comparison to the general population, people with a disability are more likely to experience abuse, neglect and violence. Some research findings suggest that as many as 80% of people with a disability experience significant abuse. The abuse experienced by people with a disability is also more likely to be severe in impact, to involve multiple incidents, to be sustained over a long period of time and to involve multiple perpetrators.

The abuse of people with disabilities is a very complex issue that can be difficult to comprehend and analyse, with a multiplicity of often inter-relating factors at play.

Some of these include the following:

- People with a disability have a heightened vulnerability to abuse.
- Abuse is most likely to be perpetrated by people known to the victim such as family members, paid caregivers, co-residents or co-workers.
- There are many forms of abuse, including: physical, sexual, psychological or emotional abuse; constraint and restrictive practices; financial, legal or civil abuse, systemic abuse; types of neglect and deprivation (for more detailed description of forms of abuse and neglect refer to Practice Example 32 and 33 in Section C).
- Some forms of abuse are likely to be intentional acts while others are more likely to result from systems failures or poor practice.
- Abuse will often involve a series of events, rather than isolated incidents. It is rarely an individual problem, even when there is a single offender, there are usually systemic factors that contribute to the abuse or fail to provide protection.
- Abuse and violence can take many forms and are often disguised by misleading language.

Contributing Factors

There are many factors that contribute to the high incidence of abuse experienced by people who have a disability. These factors include:

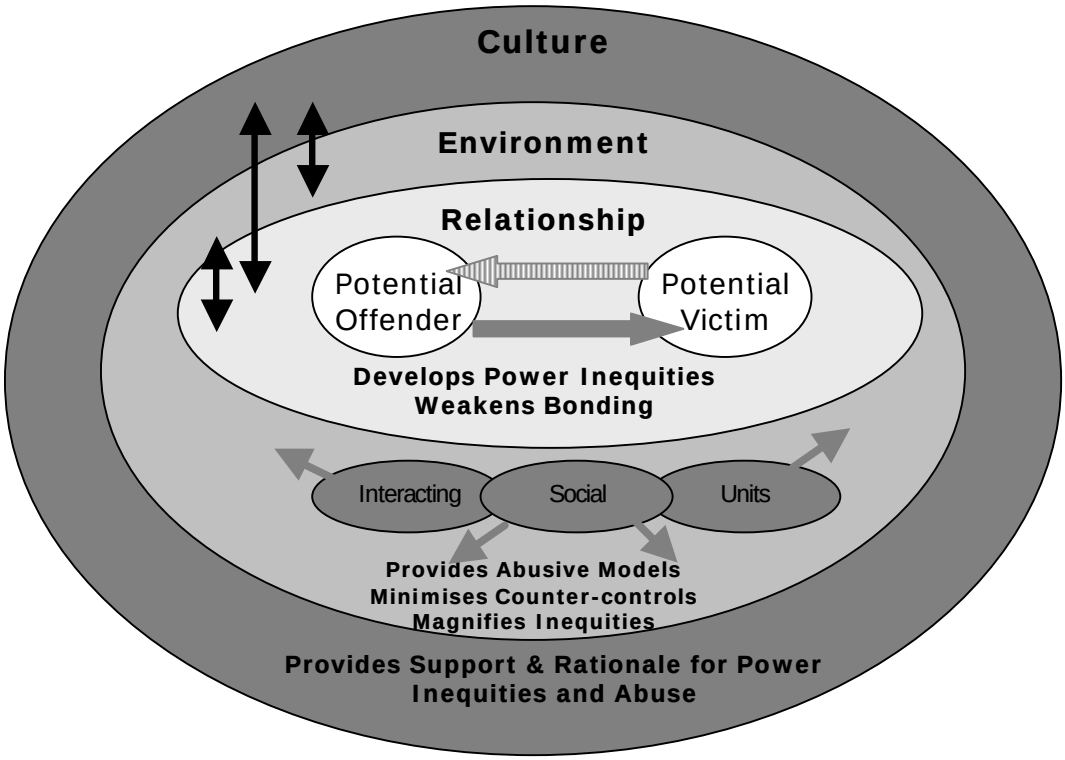
- **Characteristics of where people live and work or spend their time.** People with a disability often live or work in environments that are separate to the general community. Features of these environments can contribute to the risk of abuse.
- **Circumstances associated with reliance on services.** This may include dependence on carers for assistance with personal care or managing finances, which can provide an opportunity for abuse to occur.
- **Personal characteristics and life experiences**. People with some types of disability may have limited communication or may not have been taught that they have the right to freedom from abuse; they may be unaware of what to do and how to get help.

These factors interact to increase vulnerability. For example: the environment may create increased dependence or limit individual life experiences; personal characteristics such as limited communication skills may increase the degree to which an individual relies on support services.

A Conceptual Model Of Abuse

An integrated ecological model of abuse has been developed by Sobsey (1994), a leading researcher and author in the area of abuse and violence with regard to people with a disability. This model describes the interaction of culture, environment and relationships as core factors in how abuse can occur and how it may therefore be prevented. In order to examine the causes of abuse we must look beyond the relationship between the victim and the offender and recognise the interaction of multiple factors.

Figure 1: Integrated Ecological Model of Abuse (Reproduced from Sobsey, 1994)



The Figure above appears in Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance? By Dick Sobsey, 1994 Paul Brookes Baltimore, (page 160) with the following caption: The integrated model of abuse. Physical and psychological aspects of the interacting individuals are considered within the context of environmental and cultural factors.

Approaches To Prevention

Approaches to the prevention of abuse, crime, violence and other social problems typically include a range of primary, secondary and tertiary strategies. These may be described as:

- **Primary prevention strategies that target the community broadly.** These strategies are directed to the general public, families, workplaces, community networks and people with a disability, who may or may not be using support services.
- **Secondary prevention strategies that target populations known to be at-risk, in this case people with a disability receiving services.** These

may address risks associated with service environments and relationships that occur within service systems.

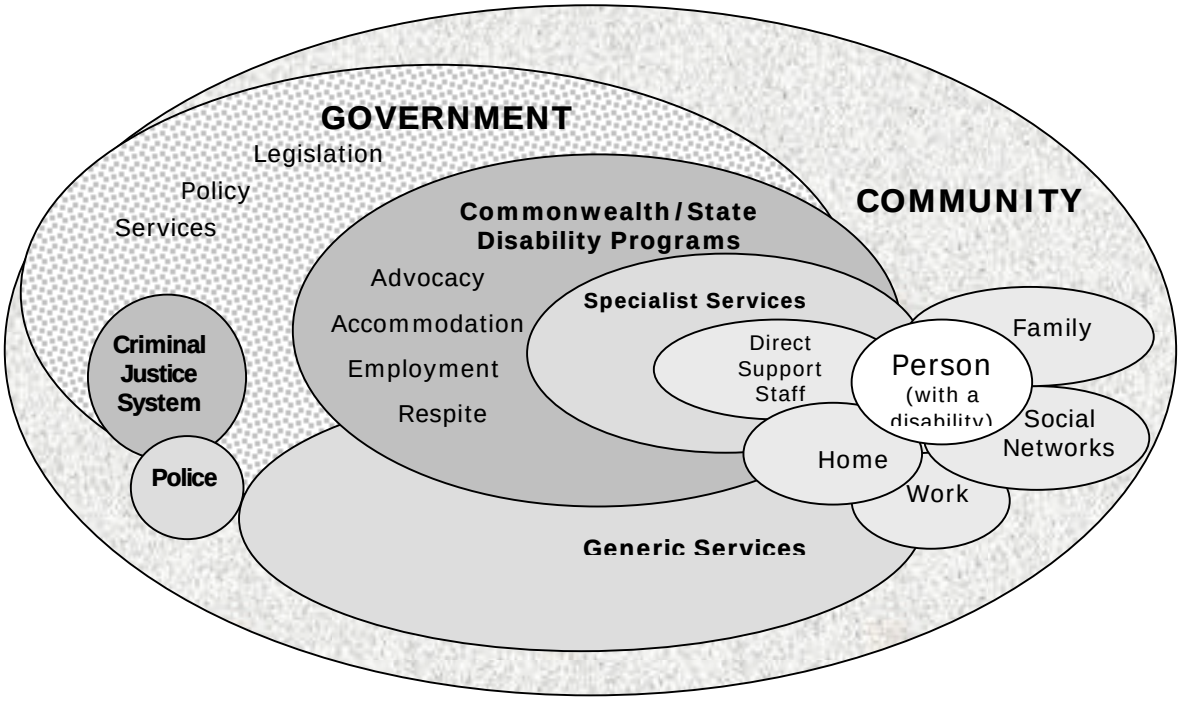
- **Tertiary prevention strategies that are responses to known incidents of abuse or significant risk of abuse.** Such strategies may prevent recurrence or reduce risk through appropriate responding and reporting, links with the criminal justice system etc.

Other approaches applied to the prevention of abuse of vulnerable populations include:

- **Health Promotion** where the focus is on encouraging the development of healthy communities and positive relationships.
- **Systems Analysis,** which examines the impact of service systems on the lives of service users and seeks to improve positive outcomes and minimise negative impact.
- **Crime Prevention** where the focus is on examining specific patterns of crime and developing intervention strategies to reduce it. This can be applied within communities, within service settings or within individual lives through risk assessment.

The diagram below maps the cultures and environments that may influence the relationships of people with a disability receiving CSDA-funded services.

Figure 2: Mapping Culture, Environment and Relationships



Specific elements such as the criminal justice system and Police have important roles in addressing the abuse of people with a disability; however, given the large number of potential connections and relationships, no single agency can be held exclusively responsible. At the same time, no element or individual is unimportant. To tackle the abuse of people with a disability, a community response and coordinated effort are required.

FRAMEWORK OVERVIEW

The *Framework for Improving Abuse Prevention* is organised into five '*Components'* of equal importance for comprehensive and holistic abuse prevention.

Each component contains a set of *'Key Principles'*, developed from the review of literature and current practice. The key principles provide a foundation for building effective abuse prevention into the operation of CSDA programs. To assist in application of the key principles, *'Mechanisms'* have been identified. The mechanisms include practical approaches that may be relevant to key principles across a number of components. *'Critical Success Factors'* have been identified for each mechanism and actual working *'Examples'* described with references for further follow up and study. These relationships are described in the figure below.

Figure 3: Framework for Improvement

SECTION A: COMPONENTS

1. UNDERSTANDING ABUSE	2. PRIMARY PREVENTION	3. PREVENTING SYSTEMS ABUSE	4. SAFER SERVICE ENVIRONMENTS	5. RESPONDING TO ABUSE OR RISK
1.6 The Language of Abuse 1.7 Patterns of Abuse 1.8 Models of Abuse and Prevention 1.9 Incidence and Impact 1.10 Research and Analysis	2.5 Inclusive Communities 2.6 Advocacy 2.7 Building Individual Resilience 2.8 Family Supports and Intervention	3.6 Systems Development 3.7 Ensuring Quality 3.8 Service Monitoring 3.9 Consumer Empowerment 3.10 Increasing Professionalism	4.6 Organisation Change & Culture 4.7 Training & Managing Support Workers 4.8 Risk Assessment 4.9 Policies, Procedures & Codes 4.10 Behaviour Intervention Guidelines	5.7 Recognition & Reporting 5.8 Vulnerable Adult Protection 5.9 Coordinated Interagency Response 5.10 Supporting Victims 5.11 Criminal Justice Issues 5.12 Community-Based Crime Prevention

SECTION B: MECHANISMS

SAFEGUARDS & RIGHTS	PARTICIPATION & COLLABORATION	SERVICE DELIVERY	AWARENESS & TRAINING	KNOWLEDGE SYSTEMS
▪ Acts and Regulations ▪ Probity Screening ▪ Independent Monitoring and Complaints Agencies ▪ Adult Protective Services	▪ Consumer Participation ▪ Cross-Sector Collaboration ▪ Cross-Government Collaboration	▪ Access and Coordination ▪ Quality Assurance ▪ Policy Resources and Guidelines	▪ People with a Disability ▪ Community Education ▪ Professional Development ▪ Professional Development in Related Sectors	▪ Defining and Describing Abuse ▪ Data Collection & Analysis ▪ Evaluation ▪ Development

EXAMPLES OF PRACTICE FROM AUSTRALIA AND OVERSEAS

The Purpose of the Framework

This Framework has been developed as a practical resource for CSDA Administrators in Commonwealth and State/Territory jurisdictions.

The Framework is not a prescriptive national approach to quality assurance or abuse prevention. Rather, it is a resource that jurisdictions may draw on when developing knowledge and guidelines tailored to their local context. The diversity across jurisdictions and service sectors with regard to population, community characteristics and the nature of services provided to people with a disability, requires a flexible approach to the development of specific strategies in service delivery and government policy.

Specific strategies and improvements in each jurisdiction would need to be developed with local knowledge and in collaboration and consultation with stakeholders including service users, service providers and related professionals.

Implementation

The implementation of this framework relies upon effective collaboration between government and non-government agencies across a range of service sectors and government portfolios. Strategic partners in addressing the abuse of people with a disability include:

- CSDA administrators and their relevant departments/agencies.
- Government and non-government providers of CSDA-funded services.
- Consumer and consumer-interest groups including advocacy and rights services.
- Service regulating or monitoring agencies.
- The Police and other law enforcement agencies.
- State/Territory child protection and children's services departments.
- Commonwealth and State/Territory education and training departments.
- Attorney Generals' and justice departments.
- Carer and family support agencies.
- Community safety and crime prevention partnerships.
- Services meeting the needs of specific groups experiencing violence.
- Agencies offering legal advice and representation.
- Health and Mental Health service providers and administrators.

Section A: Framework Components

This section, Framework Components, contains the **key principles** (KP) for a comprehensive approach to abuse prevention within CSDA jurisdictions. There are five major components and one additional component containing principles relevant to specific groups such as children who have a disability. At the end of each component the key principles are summarised and linked to mechanisms that support their implementation.

1. UNDERSTANDING ABUSE

Abuse is not easy to define, understand or measure. It is concerned with harm, which may be intentional or unintentional, severe and dramatic or insidious and widespread.

1.1 THE LANGUAGE OF ABUSE

The need for clear and consistent language to describe abuse has been recognised across service sectors working with vulnerable populations including children, older people, people with disability and people with mental illness.

> *"Abuse is a continuum of circumstances which most would regard as clearly harmful through to situations which might be seen as merely inappropriate and non-optimal. Different groups will draw the line in different places…it can therefore be difficult to know exactly where to draw the line between the inappropriate and the unacceptable." (Cashmore et al 1994)*

The term 'abuse' has no legal meaning as a criminal act; however, the offences that may constitute abuse (for example, assault, unlawful imprisonment, sexual assault) are unlawful. It is important that terminology is not used to trivialise or decriminalise offences. Criminal acts should be recognised as such and should not be described by terms such as 'aversive treatment' or 'inappropriate behaviour', neglect or exploitation. Using 'softer' terminology prevents appropriate recognition of and response to abuse.

Equally important is the need to identify abuse as more than isolated criminal acts or incidents. The systemic nature of abuse and the many ways in which people with a disability are at risk of abuse must be acknowledged if prevention is to be effective.

Improved description aids recognition and identification of abuse, it also raises the importance of taking the appropriate action when responding to abuse.

Mechanisms that apply clear and consistent language will contribute to:

- Education and professional training with regard to abuse.
- Developing systems that aid the identification of abuse.
- The development of appropriate responses to specific forms of abuse.
- Monitoring the incidence of abuse and specific forms of abuse.
- Evaluating the effectiveness of abuse prevention strategies.

KP 1: USE CONSISTENT TERMINOLOGY. *The language of abuse is as consistent as possible across jurisdictions and where possible across service sectors.*
KP 2: DESCRIBE ABUSE APPROPRIATELY AND FULLY. *Descriptions do not trivialise or decriminalise acts of abuse but rather provide a basis for addressing systematic harm perpetrated on people with a disability* *Definitions of abuse used within disability service systems include descriptions and examples.*

1.2 PATTERNS OF ABUSE

People with a disability are more likely to experience abuse by someone they know, either a family member, paid support worker or another person with a disability especially those clustered with their victims in service settings.

"While many types of abuse are overt and easily recognised, many are subtle and unconsciously perpetrated… We need to know the identity and life experiences of individuals to understand how abuse is perpetrated." [Conway et al, 1995]

Patterns of abuse include:

- **Long-term abuse** in the context of an ongoing family relationship.
- **Serial abusing** where the perpetrator seeks out vulnerable individuals. Sexual abuse usually falls into this pattern, as do some forms of financial abuse.
- **Opportunistic abuse** such as theft occurring because money or possessions are left around or easily taken.
- **Situational abuse** that arises because pressures have built up and/or because of difficult or challenging behaviour.
- **Neglect** of a person's needs, because those around him or her are unable to provide care or there is a lack of services or inappropriate services. This includes failure to access key service such as health care, dentistry, prosthesis.
- **Institutional abuse** which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service.
- **Unacceptable 'treatments' or programs** which include punishment such as withholding of food and drink, seclusion, unnecessary or unauthorised use of control and restraint or over-medication.
- **Failure** of agencies to ensure staff receive appropriate guidance on anti-discriminatory practice and cultural sensitivity.
- **Misappropriation** of the person's money by others, fraud or intimidation.
- **Vulnerability** to various forms of abuse may be interconnected and prevention strategies may serve to reduce the likelihood of various forms of abuse.

KP 3: DEVELOP FULL UNDERSTANDING OF WHAT ABUSE IS.

The prevention of abuse requires understanding both the broad and systemic nature of abuse or neglect, in addition to specific acts or behaviour that is harmful and in some cases criminal.

1.3 MODELS OF ABUSE AND ABUSE PREVENTION

A variety of models of prevention can be applied to the disability services sector.

> *"While disability is associated with risk for abuse, it is important to avoid the assumption that disability is a direct cause of vulnerability… studies suggest a more complex relationship, one that is characterised by interactions between disability, society, culture and violence."*
> *[Sobsey, 1994]*

Sobsey (1994) has developed an integrated ecological model of abuse in the lives of people with a disability. This model places emphasis on the relationship between potential offenders and potential victims within the context of the immediate environment and broader cultural context. The components of Sobsey's model include:

- **Relationships** between potential offenders and potential victims which can be influenced by characteristics of the victim such as dependency, learned compliance, and impaired communication or physical defences; and characteristics of the potential offender such as a need for control, exposure to abusive behaviour, devaluing attitudes and low attachment to the victim.
- **Environments** that can emphasise control, isolate people from society, attract abusers, conceal abusive behaviour, dehumanise people, and discourage attachment**.**
- **Culture** that devalues people with a disability, teaches compliance, denies problems, discourages attachment, objectifies potential victims etc.

Other conceptual models have potential value to the development of prevention strategies, including the primary, secondary and tertiary model of influence developed in the public health arena and models of crime prevention, such as crime prevention through social supports, community-based crime prevention and situational crime prevention. Abuse can be examined within service systems to identify systemic causes and preventions. It can also be addressed through health promotion activities to create healthy attitudes and environments that discourage abuse.

Prevention strategies need to be tailored to the problem they address and the context in which they are to be implemented. Within this, there is a need to recognise both generic factors such as cultural attitudes and beliefs, as well as specific risk factors associated with vulnerability and opportunity.

See also the 'Background' information provided in the previous section of this report.

KP 4: PREVENTION EFFORTS TARGET THE CULTURAL, ENVIRONMENTAL AND INTERPERSONAL CAUSES OF ABUSE.

The effective prevention of abuse requires an ecological approach to address causal factors in culture, environments and relationships.

Strategies to prevent abuse incorporate broad approaches to address generic risk factors such as isolation and specific approaches to target risk factors associated with particular types of abuse such as the predatory behaviour of sexual assault offenders.

1.4 INCIDENCE AND IMPACT

The incidence of abuse is much higher among people with a disability than the broader population. There is evidence that people with a disability are at an increased risk of experiencing repeated and multiple forms of abuse.

Difficulties persist in establishing incidence due to inconsistent reporting, under-reporting, and differences in sampling methodology. Research examining incidence finds not only high levels of specific forms of abuse within this population but estimates that the incidence of hidden abuse is much higher and that the majority of abuse is unreported. The capacity of services to reduce abuse in the lives of people with a disability relies on identification, prevention and appropriate response. Reported incidents of violence and abuse serve to indicate the extent of the problem rather than to define it. Understanding the impact that it has is also required in order to develop and resource effective prevention.

"Children and adults with disability experience increased risk for physical, sexual and other forms of abuse. They are not only more likely to be abused but when they are abused, the abuse is more likely to be chronic and severe." (Sobsey, 1994]

See also **Section 1.5 Research and Analysis** (below) and **Section 5.1 Recognition and Reporting** for issues regarding data collection and reporting.

KP 5: THE INCIDENCE AND IMPACT OF ABUSE IS RECOGNISED.

Increased data collection and analysis with regard to the incidence of various forms of abuse across different service types, will assist the development and evaluation of prevention strategies.

Some forms of abuse are not well understood and therefore require more attention in training and awareness raising, eg financial abuse.

Identifying the impact of abuse and the cost of abuse to individuals and the broader community can assist to direct resources to prevention.

1.5 RESEARCH AND ANALYSIS

Research and analysis informs practice in service systems, leading to improved outcomes for people with a disability. Knowledge gained from research and monitoring activities needs to be assessed and synthesised into systems in collaboration with consumers and service providers through a process of consultation, testing and evaluation. There is a need for ongoing research to allow continuous improvement in the capacity of the community to:

- Better identify the problem of abuse in the lives of people with a disability;
- Increase knowledge and awareness regarding the incidence, nature and causes of abuse with regard to people with a disability;
- Adapt responses to abuse prevention across different environments and circumstances; and
- Evaluate the effectiveness of abuse prevention strategies.

KP 6: THE RESEARCH AND REVIEW OF ABUSE IS CONTINUAL.

Ongoing research and review aids problem identification.

The development of effective prevention approaches within service systems requires more research across the broad range of service types provided in Australia.

LINKS TO MECHANISMS AND PRACTICE EXAMPLES

KEY PRINCIPLES	MECHANISMS	PRACTICE EXAMPLES
1. Use consistent terminology. 2. Describe abuse appropriately and fully. 3. Develop full understanding of what abuse is. 4. Prevention efforts target the cultural, environmental and interpersonal causes of abuse. 5. The incidence and impact of abuse is recognised. 6. The research and review of abuse is continual.	PARTICIPATION & COLLABORATION ➔ Cross-sector collaboration on language and prevention strategies SERVICE DELIVERY ➔ Broad approaches to address generic risk factors ➔ Specific approaches to target risk factors associated with particular types of abuse AWARENESS & TRAINING ➔ Understanding both the broad and systemic nature of abuse or neglect KNOWLEDGE SYSTEMS ➔ An ecological approach to address causal factors ➔ Mechanisms to identify the impact of abuse ➔ Increased data collection and analysis ➔ Definitions and descriptions of abuse ➔ Research agenda	☞ Practice Example 2: Descriptions of Abuse and Neglect. ☞ Practice Example 1: Plain English Definition of Abuse/Neglect. ☞ Practice Example 16: Approaches to Promoting Best Practice.

2. PRIMARY PREVENTION

The primary prevention of abuse has as its target the broader community or cultural context in which abuse occurs. The literature regarding the abuse of people with a disability recognises that although most abuse occurs within service settings, services operate within a broader cultural context which impacts on the service environment and the vulnerability to abuse of people with a disability.

Addressing factors in the cultural context, which increase or decrease the likelihood of abuse occurring, are most likely to have a long-term impact on abuse prevention.

> *"The prevention of the abuse and neglect of (older) vulnerable adults is a community challenge which will not be resolved quickly by one person or one approach. It will require a community effort to create an environment which reaffirms the right of [older] adults to self-determination, respect and dignity." (Health and Welfare Canada, 1993a – brackets added)*

2.1 INCLUSIVE COMMUNITIES

The high incidence of the abuse of people with a disability has been linked to the devalued status that people with a disability have had in the community and the isolation of people in institutional settings. This has resulted in community ignorance of not only individual instances of abuse, but also the abusive nature of institutional settings. Inclusion for people with a disability is a core principle underlying Disability Services and Disability Discrimination legislation across Australia.

Reducing Isolation

Reducing congregate care and supporting people to live in the community is a key strategy to increase inclusion.

Australian CSDA programs in all States, (excluding the ACT and NT where it is not applicable), have a planned approach to replacing congregate residential service facilities with community-based integrated service models.

> *"The current trend toward community services has reduced the population of institutions, but it has also resulted in a greater concentration of people with the most severe needs living in institutional settings. Until and unless good alternatives can be provided for every individual in the community, institutions will continue to exist. As long as they exist, providing the best possible quality of life to the people who inhabit them is crucial." [Sobsey, 1994]*

Despite these commitments, it is likely to be some time before segregated services are no longer a significant part of the way in which services to people with a disability are provided.

Strategies to reduce social isolation for those people who continue to live in congregate care will assist to reduce the likelihood of abuse occurring within these settings. Examples of strategies include programs such as *Community Visitors* (see Example 5 in Section C) and *Citizen Advocates*; increased access to employment and alternative day programs; and programs to facilitate greater access to community facilities or activities.

KP 7: INCREASE SOCIAL INTEGRATION AND REDUCE SEGREGATION.

Integration and social connections reduce the likelihood of abuse, facilitate identification & response.

Specific programs such as community visitors or citizen advocates address the isolation of people at high-risk of social disconnection and abuse.

Enhancing Valued Status and Raising Awareness

At an individual level, valued status is achieved through opportunities to form relationships, demonstrate competence, exercise citizenship rights and meet social responsibilities. Addressing barriers and providing appropriate and coordinated supports enhances opportunities for people with a disability.

"All of us are unconscious of much of the harm that we do – we are all perpetrators of abuse by our support of many service practices or our silence. By becoming conscious of what we are doing, we take on a moral responsibility to minimise further damage." (Conway et al, 1995).

At a community level, campaigns and school-based education have been widely used to promote positive attitudes and influence behaviour. Increased awareness of the problem of abuse encourages abused or neglected persons to seek assistance. It also helps members of the broader community to identify abuse and neglect and intervene appropriately.

KP 8: PROMOTE THE VALUED STATUS OF PEOPLE WITH A DISABILITY AND RAISE AWARENESS.

Enhance valued status by addressing barriers to inclusion and providing appropriate supports.

Enhance community attitudes toward people with a disability and the prevention of abuse.

Increasing Social and Economic Participation

Strategies to address financial dependence and poverty among people with a disability include improving access to employment through mainstream and specialist services and improving income support arrangements through welfare reform (occurring outside the CSDA).

The failure to ensure that people with a disability experience industry-standard minimum wages or appropriate levels of remuneration is a form of financial abuse. Quality assurance reforms in the Commonwealth Disability Employment Services sector will aim to address this and raise the standards in employment services through continuous quality improvement and stronger sanctions.

There has been limited attention to overly restrictive practices in the management of the private finances of service users in residential support services. In a recent national satisfaction survey, consumers identified greater access to personal funds as a priority area of improvement in service delivery. The accountability of professionals managing the personal finances of service users is also an area requiring further improvement. Specific strategies might be developed to address this issue, as contributing factors and potential strategies to improve access and accountability are likely to be complex.

KP 9: INCREASE THE SOCIOECONOMIC PARTICIPATION OF PEOPLE WITH A DISABILITY.

Reducing financial abuse within CSDA-funded disability services has the potential to increase the financial independence of consumers and their satisfaction with support provided.

2.2 ADVOCACY

A range of advocacy services contribute to abuse prevention: those that assist individual people with disabilities and those that focus on issues that are important to many people with disabilities. A recent review of the National Disability Advocacy Program has recommended that the prevention of abuse and mistreatment become a stated objective of the program.

National and State CSDA reviews have identified the need to improve access to advocacy and links between organisations and services. It is the responsibility of the service provider to identify the need for assistance and to actively seek the involvement of independent advocacy on behalf of the resident. Facilitating access to advocates therefore needs to be linked to risk assessment within service settings and service performance monitoring.

Collective advocacy for people with a disability can help to address systematic and social inequity. In order to be effective, collective advocacy must be independent of funding and service delivery agencies in order to have appropriate influence over the broader socio-political environment in which policy is formed and services operate. Examples of effective structured approaches to collective advocacy have included the Victorian Disability Services Review Panel and the NSW Community Services Commission.

KP 10: ADVOCATES ARE ACCESSIBLE AND EFFECTIVE FOR INDIVIDUALS, GROUPS AND POPULATIONS OF PEOPLE WITH A DISABILITY WITHIN SERVICE SYSTEMS.

Effective advocacy mechanisms operate to increase inclusiveness and reduce the abuse and unfair treatment of people with a disability.

Advocates are available to people who have experienced abuse, are at-risk of abuse or where people with a disability are offenders and may be involved in the criminal justice system.

2.3 BUILDING INDIVIDUAL RESILIENCE

Individual characteristics can increase vulnerability to abuse or enhance resilience to abuse. Building individual resilience can reduce the likelihood that a person or persons will be victimised and potentially reduce the severity or impact of abuse if it does occur. Individual resilience is not effective on its own, environment and cultural change must provide an appropriate context for self-empowerment and protection against abuse.

There has been a substantial amount of work undertaken to identify causal factors and develop resources that reduce individual vulnerability. For example much work has been done to develop programs, resources and strategies that aim to:

- Educate people with regard to their rights as citizens and service users.
- Increase individual independence and decision-making within services.
- Enhance communication.
- Increase choice and opportunity.
- Provide supports to improve mobility and freedom

"Training (people with disabilities) can and does help to prevent abuse, but it is important to recognise that many abused people with disabilities, as with other victims of abuse, face extreme power inequities that no amount of individual training can overcome." (Sobsey 1994)

of movement.

- Reduce over-compliant behaviour.
- Build knowledge and skills.
- Increase self-esteem.

Resources such as training programs, information packages, audio/visual learning and communications technology initiatives have been developed across Australian CSDA jurisdictions. These resources cater to specific populations of people with a disability with diverse communication needs and are often available to individuals or organisations through contracted specialist providers such as Family Planning Associations.

There is little evidence of evaluation of these resources with regard to either their effectiveness in building individual resilience or the extent to which they have been distributed and used. It is also unclear if resources are adequately available to specific populations such as Aboriginal and Torres Strait Islander communities; or other culture and language groups; people with same gender sexual preference, and people living in rural and remote communities.

KP 11: INDIVIDUAL RESILIENCE TO ABUSE IS ENHANCED. *Individual vulnerability is identified in risk assessment and individual support planning.* *Resources for building individual resilience are accessible and actively promoted to individuals and to services across geographic and social demographics.*
KP 12: RESOURCES TO BUILD INDIVIDUAL RESILIENCE ARE MANAGED EFFECTIVELY. *Appropriately target and coordinate resources for building resilience against abuse.* *Training and information resources are evaluated for their effectiveness.*

2.4 FAMILY SUPPORTS AND INTERVENTION

In the family environment, stress has been linked to abuse and violence in research regarding domestic violence, the abuse of children, older people and people with a disability.

Devising ways to divert stress is seen as a major step in short circuiting the potential for abuse. Family risk factors, which may lead to an increased risk of abuse, include: isolation, disruptions in attachment, family member attributes, substance abuse, history of previous family violence, perceived stress.

Issues that have been identified with regard to family-centred supports include:

- Particular supports such as parenting training, appear to be provided on an ad-hoc basis.
- There is high unmet need for respite services and significant opportunities for improving these services.

"In general, natural families who are well embedded in their communities with strong attachments among all members of the family, provide relatively safe environments for people with disabilities. Simply keeping children in their natural families and avoiding placement in service alternatives is an excellent abuse prevention strategy. Unfortunately sometimes abuse can and does occur within the natural family itself." (Sobsey, 1994)

- Access to generic community services can be limited by the capacity of these services to cater to families, children and adults with a disability.
- Families living in communities that are geographically isolated or socially or economically disadvantaged can face additional difficulty accessing both generic and specialist supports.
- Service coordination is inconsistent across jurisdictions.
- Links between services including mental health and child protection services have been identified as problematic in some jurisdictions.
- There is a lack of appropriate intervention programs for families in which a child or adult with a disability is at-risk of abuse.

Within the CSDA service system, two strategies that have been identified to improve abuse prevention within the family setting are improving service coordination and enhancing risk assessment. Both of these strategies increase the capacity of the system to provide appropriate supports to families earlier, with the potential to prevent family crisis. Links might also be strengthened between approaches within the CSDA jurisdictions and broader initiatives that aim to strengthen and support families.

KP 13: USE A RANGE OF STRATEGIES TO SUPPORT FAMILIES AND REDUCE FAMILY STRESS

Access to appropriate services can reduce and prevent family stress thereby reducing the risk of abuse.

Cross-sector collaboration improves outcomes for families through better access to supports.

Families that have a member who has a disability require the same access to mainstream family support systems as other families, outcomes for these families should be included in policy, program reviews and research activities.

KP 14: DEVELOP AND RESOURCE RESPONSES TO ABUSE IN THE FAMILY SETTING

Further research is needed to develop approaches for identifying risk and appropriate family-centred intervention.

LINKS TO MECHANISMS AND PRACTICE EXAMPLES

KEY PRINCIPLES	MECHANISMS	PRACTICE EXAMPLES
7. Increase social integration and reduce segregation. 8. Promote the valued status of people with a disability and raise awareness. 9. Increase the socio-economic participation of people with a disability. 10. Advocates are accessible and effective for individuals, groups and populations of people with a disability within service systems. 11. Individual resilience to abuse is enhanced. 12. Resources to build individual resilience are managed effectively. 13. Use a range of strategies to support families and reduce family stress. 14. Develop and resource responses to abuse in the family setting.	PARTICIPATION & COLLABORATION ☞ Advocacy ☞ Family supports coordination SERVICE DELIVERY ☞ Individual risk assessment ☞ Integration and social connections ☞ Reducing financial abuse through targeted approaches ☞ Programs to address social isolation AWARENESS & TRAINING ☞ Resources for building individual resilience ☞ Coordination of resources for building resilience ☞ Community education KNOWLEDGE SYSTEMS ☞ Evaluation of training and information resources ☞ Further research for identifying risk and appropriate family-centred intervention.	☞ Example 15: Proposed Quality Assurance System - Commonwealth Disability Programs. ☞ Example 28: The Thanbarren (Early Intervention) Project. ☞ Example 29: The Montreal Prevention Project . ☞ Example 43: Oregan Social Learning Centre Parent Training Programs. ☞ Example 45: The Children at Risk Program.

3. PREVENTING SYSTEMS ABUSE

In its simplest form, systems abuse occurs when the needs of people with a disability are not recognised and essential services are not provided or may be inadequate, inappropriate or poorly coordinated. The impact on individuals can include neglect or abuse resulting from poor practice, exclusion from community life and the loss of basic human rights.

Systems abuse is caused by factors such as inadequate resources, lack of accountability, gaps between policy and practice, inadequate skills or information, and the tendency for systems to become self-serving rather than responsive to need and open to consumer influence.

Systems abuse is addressed through achieving accountability at all levels, coordination between agencies, informed decision-making, ongoing development, focus on program objectives and a strong consumer voice.

> *"Systems abuse occurs when preventable harm is done to children or adults with a disability in the context of policies or programs that are designed to assist them. Individual harm occurs when the capacity of a service system to provide adequate supports is compromised by sub-optimum services, policies that fail to prevent neglect or abuse, or system failures that prevent individual needs being met." [Cashmore et al, 1994]*

3.1 SYSTEMS DEVELOPMENT

Systems improvement contributes to the prevention of abuse and the overall accountability of services systems. The following elements are often identified as critical for achieving an effective service system for people with a disability:

- The focus is on outcomes for individuals.
- The supports provided are individually tailored to meet individual needs and preferences, which may change over time and circumstances.
- Service systems are culturally sensitive and inclusive, with the capacity to respond appropriately to people of Aboriginal or Torres Strait Islander descent and individuals from a diversity of cultural and linguistic backgrounds.
- There is effective linking between service components eg funding and performance monitoring.
- Services and supports are coordinated and provided in a timely way that prevents difficulties for individuals arising or compounding.

> *"…everyone will be safeguarded against abuse, neglect or poor treatment while receiving care. Standards will be clearer, checks will be tighter and the regional Commissions for Care Standards will have strong and swift powers to put a stop to any abuse where it occurs."*
> *(UK Department of Health, Modernising Social Standards. 2000).*

There are specific systemic improvements that have a direct impact on the risk of abuse to individuals. Examples include:

- **Individual and portable funding** that allows individuals to change services and change the supports that they receive, increasing independence and reducing the risk of abuse. The implementation of case-based funding in Commonwealth employment programs is one example (see Practice Example 20 in Section C).

- **Assessment and access mechanisms** (that provide access to supports based on relative need and available resources) involve risk assessment including the potential risk of becoming either a victim of abuse or an offender. The development of improved service access systems in NSW (see Practice Example 38) and Victoria are examples of this.
- The development of **performance data** to inform planning and decision-making (which may include individual outcomes with regard to increased resilience to abuse, reduced risk of violence or harm).
- Increased **links between purchasing services and monitoring services** has been occurring across a number of jurisdictions (see Practice Example 36).
- The development of **early intervention** approaches to providing supports such as Local Area Coordination has been introduced in several Australian States (see Practice Example 37).

KP 15: APPROACHES TO IMPROVEMENT OF DISABILITY SERVICE SYSTEMS ADDRESS ABUSE PREVENTION.

Performance measurement and evaluation includes accountability for abuse prevention. Performance data includes information on abuse prevention.

Service contracts and performance measures incorporate approaches to preventing abuse and building resilience.

Funding mechanisms identify and respond to individuals with high risk of abuse and prioritise access to appropriate supports.

Funding decisions respond to evidence of breach of the Disability Services Act or poor practice.

3.2 ENSURING QUALITY

The prevention of abuse is often recognised as a major driving force in modern quality assurance systems within human service sectors.

Governments in Australia and overseas have recognised the need to improve public confidence in the quality of services provided to vulnerable people including older people, people with a disability and children. Internationally and within Australia, quality standards are being raised across the spectrum of human services.

Major advances in quality systems in human services, with some notable exceptions, tend to have been pioneered in sectors other than disability services, including aged care, child care and the broad spectrum of social services including health care. Analysis of international and Australian trends in human service sectors has identified the following closely linked components of modern quality assurance systems that contribute to improved service delivery and decrease the likelihood of abuse:

- Independent assessment, monitoring and review against quality standards or benchmarks underpinned by legislation.
- Increasing professional standards.
- Consumer participation in quality assurance.
- Independent consumer complaints mechanisms.

- Supports and resources for service providers and consumers provided by government.

The components above have been incorporated in key principles of this Framework. Individual components are less effective when not linked together through a quality assurance system that is appropriate to the local context and has the support of service providers and consumers.

Self-assessment of the implementation of quality standards by services is common in human service/disability service systems and is an important part of any quality assessment process. However, systems that do not also incorporate external quality assessment or review of organisational practice risk maintaining substantial differentials in practice quality between organisations, and potentially entrench poor practices in some organisations that are not exposed to external scrutiny or assessed within a wider service system context. Consequently, the most robust approaches employ a combination of self-assessment and external review.

The development of integrated quality systems has been undertaken in some CSDA jurisdictions, in collaboration with service providers and consumers. An example is the Queensland Framework for the Disability Sector, described in Section 3.2 of the Part 2: Review of Literature and Current Practice (Figure 11). This system has a vision supported by principles and three components: 1) Quality Enhancement, 2) Participation and Feedback and 3) Standards Monitoring.

KP 16: SERVICE QUALITY IS ASSESSED AGAINST BENCHMARKS THAT ARE OUTCOME FOCUSED, ESTABLISH CLEAR MINIMUM STANDARDS AND PROMOTE CONTINUOUS IMPROVEMENT. *Quality benchmarks provide minimum standards that reduce the risk of abuse.* *Quality benchmarks are raised as overall standards and expectations increase.*
KP 17: STRONG MECHANISMS ENSURE COMPLIANCE WITH DISABILITY SERVICES LEGISLATION. *Legislation governing the provision of Disability Services is the 'bottom-line' for abuse prevention.*

3.3 SERVICE MONITORING

Independent, external monitoring of service delivery and consumer issues is a key feature of improved quality assurance within human service sectors, in Australia and overseas.

Increasingly government purchasing agencies require independent accreditation/certification bodies to perform comprehensive service reviews against quality standards to determine the eligibility of organisations for initial and ongoing funding or approval to provide services.

"Independent monitoring must hold management of each service responsible for all incidents of abuse, including systematic procedures that result in abuse." [Conway et al, 1995]

Effective monitoring can contribute to the early detection and prevention of, and response to, the abuse of people within services. It serves to increase the accountability of both government and service providers to the consumer population and to the broader community. Independent

monitoring agencies can also provide a mechanism for raising social and political awareness with regard to resource needs for vulnerable populations.

Evidence from research within the disability services sector and across other human service sectors identified the following requirements for effective service monitoring:

- An agency that is independent of both the providers and the funding agency to undertake monitoring activities.
- There are clear response guidelines for non-compliance against required quality standards including sanctions such as restrictions on current or future funding.
- Monitoring agencies have a broad range of powers for investigating and acting on complaints, concerns and other indicators of poor performance.
- Monitoring should occur in the service delivery environment and involve direct observation, verification and consultation with consumers.
- Incentives reward leadership and recognise good practice.
- Monitoring encourages continual quality improvement and feeds into a learning cycle that informs the development of improved practices.

A number of States and Territories have mechanisms for independent monitoring of services provided under the CSDA, that are distinct from performance monitoring related to the funding of services. These monitoring mechanisms are established under separate legislation. As they are generally not developed specifically for CSDA services, not all independent monitoring mechanisms will cover all CSDA specialist service types.

It is recognised that to ensure effectiveness in service monitoring, the sector must have confidence in the process. Any development or enhancement of current mechanisms should be undertaken in collaboration with service providers, consumers and other stakeholders.

KP 18: MONITORING OF SERVICES IS INDEPENDENT OF THE PURCHASER AND PROVIDER.

Independent skilled quality assurance assessors have contact with consumers, staff and management, within the service context and are free from alliance with either purchaser or provider.

There is consumer and public confidence in the independence of the service quality assessments.

3.4 CONSUMER EMPOWERMENT

"The right to be free from abuse is so fundamental that it is assumed that everyone knows that they have this right. That is not the case. People generally believe what their experience has taught them, and many people with disabilities must learn they have rights before they can exercise those rights." (Sobsey, 1994)

An overriding theme in the literature examining why people with a disability are vulnerable to abuse is that this population have been systematically marginalised and denied individual and social power. Empowering people with a disability in their relationship with service providers and the broader service system is a fundamental approach to preventing abuse.

Three areas of particular relevance to abuse prevention have been identified from critical analysis of the literature.

Consumer Rights and Influence

Within service systems consumer empowerment is supported at a global level by effective representation and at an individual level by an awareness of individual rights and the capacity to represent individual interests.

Disability Services legislation and Service Standards include requirements that consumer rights are protected and promoted through policy and practice. Due to the highly dependent nature of the relationship between some people with a disability and service providers, safeguards are needed to protect and support individual rights within service systems.

Strategies to increase consumer rights and influence aim to empower individuals to exercise their rights in their relationship to service providers and to access independent advocacy or representation when they are at risk. These strategies include consumer education, information and resources; clear statements of consumer rights in charters or declarations and effective representation mechanisms.

There is consensus in the literature that there is a significant power imbalance between service providers and service users. This imbalance is too significant to vest the responsibility for consumer education and support in service providers and within the service context. Broader system-level approaches to providing consumers with information and assistance are needed, provided through agencies independent of purchasers and providers.

KP 19: CONSUMERS ARE AWARE OF THEIR RIGHTS AND ABLE TO EXERCISE INFLUENCE.

Consumers receive information and where appropriate training or advocacy support to understand their rights and participate in decision-making at the individual, service and system level.

Participation in Quality Assurance

Consumer participation in quality assurance processes contributes to a culture of empowerment and responsiveness within service environments.

Currently, consumer participation in quality assurance varies across CSDA jurisdictions. In those jurisdictions where participation is required, service providers are required to involve consumers in self-assessment against Disability Service Standards.

"Consumer involvement at every stage (in quality assurance) should be active, independent and supported by advocacy where needed. Practical support and training must be made available to consumers to facilitate this high level of participation."
[Assuring Quality, 1997)

Better outcomes have been achieved in consumer participation where government has provided independent support or training for consumer participation and made consumer representation a requirement in the quality assurance system.

KP 20: CONSUMERS ARE ACTIVELY INVOLVED IN QUALITY ASSURANCE & SERVICE MONITORING.

Consumer participation is supported by practical support and training.

Consumer participation is assisted by independent advocacy where needed.

Complaints Mechanisms

The importance of providing a mechanism for resolving consumer complaints has been widely recognised across many industries and sectors, resulting in the establishment of industry specific complaints bodies in most. The Australian Standard AS4269 1995 outlines the essential elements for an effective complaints handling process.

The effectiveness of complaint mechanisms can be enhanced through:

- Easy access to complaints agencies and encouraging consumers to raise concerns.
- Providing adequate resources for complaints agencies to respond in a timely and effective way.
- Providing complaints agencies with a range of powers to address problems.

System improvements can flow from an active, structured approach to the review and analysis of patterns of complaints and effective approaches to addressing issues.

International and Australian approaches in other human service sectors tend to streamline access to complaints mechanisms by providing one primary point of contact across different services commonly used by a defined population. Consumers may still choose to complain through an alternative mechanism such as a peak body or advocacy organisations, but streamlining allows easier identification of where to go for help.

KP 21: CONSUMERS HAVE ACCESS TO INDEPENDENT COMPLAINTS MECHANISMS. *Complaint mechanisms meet the Australian Standard AS4269.* *Independent complaints mechanisms provide transparency and consumer confidence.*
KP 22: REVIEW OF CONSUMER COMPLAINTS INFORMS QUALITY IMPROVEMENT. *Both within service provider organisations and across the broader CSDA consumer complaints are reviewed to improve service practices.*

3.5 INCREASING PROFESSIONALISM

The risk of abuse can be significantly decreased by creating services that support both consumers and staff, attracting staff with the greatest potential and thoroughly screening staff to prevent potential abusers from entering services.

Opportunities to significantly reduce the risk of abuse within services includes:

- Enhance the quality of professionals working in the disability services sector by improving remuneration and working conditions, increasing the valued status of this work, developing career paths within the sector and increasing access to skills development opportunities.
- Increase staff retention and stability, to enhance the capacity for staff to develop appropriate relationships with

"The people who work in social care are called on to respond to some of the most demanding, often distressing and intractable human problems. Yet there are few public accolades for getting it right and virulent criticism for getting it wrong. Staff can feel embattled and undervalued, and their morale suffers." *(UK Department of Health)*

consumers and build skills in support and communication.

- Raise pre-employment training and qualification requirements in disability services.
- Increase probity screening of employees, volunteers and other people within a service environment who have access to people who are vulnerable.

Mechanisms for achieving the above include the development of purchasing systems and quality assurance systems that promote good practice in remuneration, working conditions, and human resource management. Regulatory and quality assurance mechanisms can also be used to establish standards with regard to the competency of people working in the sector and promote continuous improvement in this area.

CSDA jurisdictions typically have protocols for service providers to undertake criminal record checks on prospective employees. However, few people who perpetrate abuse against people with a disability are prosecuted and convicted of a crime. It is more common for people to be dismissed or to resign and for no record to be made. It is therefore essential that probity screening go beyond criminal history checks.

See also Component 4.1: Organisation Change and Culture and Component 4.2: Training and Managing Support Workers.

KP 23: SYSTEMS DEVELOPMENT AND QUALITY ASSURANCE RAISE PROFESSIONAL STANDARDS IN DISABILITY SERVICES.

Professional standards include competency, career paths, remuneration, working conditions and opportunities for ongoing skill development.

Collaborate with vocational training agencies to promote qualifications.

KP 24: PROBITY SCREENING PROTECTS VULNERABLE PEOPLE WITHIN DISABILITY SERVICES FROM PREDATORY OFFENDERS.

Research and analysis supports mandatory probity screening in all service settings in which employees (paid or unpaid) work with adults or children who are vulnerable to abuse due to individual or environmental factors or the nature of the supports provided.

As convictions for abuse are relatively low probity screening should include the application of a 'reasonable risk' test.

LINKS TO MECHANISMS AND PRACTICE EXAMPLES

KEY PRINCIPLES	MECHANISMS	PRACTICE EXAMPLES
15. Approaches to improvement of disability service systems address abuse prevention. 16. Service quality is assessed against benchmarks that are outcome focused, establish clear minimum standards and promote continuous improvement. 17. Strong mechanisms ensure compliance with disability services legislation. 18. Monitoring of services is independent of the purchaser and provider. 19. Consumers are aware of their rights and able to exercise influence. 20. Consumers are actively involved in quality assurance and service monitoring. 21. Consumers have access to independent complaints mechanisms. 22. Review of consumer complaints informs quality improvement. 23. Systems development and quality assurance raise professional standards in disability services. 24. Probity screening protects vulnerable people within disability services from predatory offenders.	SAFEGUARDS & RIGHTS ☞ Probity screening and recruitment practice ☞ Independent complaints mechanisms ☞ Performance measurement ☞ Funding decisions respond to evidence of breach of the DSA or poor practice. PARTICIPATION & COLLABORATION ☞ Independent advocacy for consumer participation in quality assurance ☞ Collaboration with vocational training agencies SERVICE DELIVERY ☞ Independent service quality assessments. ☞ Funding mechanisms that identify and respond to risk of abuse ☞ Quality benchmarks provide minimum standards that reduce the risk of abuse. ☞ Independent skilled quality assurance assessors AWARENESS & TRAINING ☞ Consumer information, training and advocacy support ☞ Professional standards KNOWLEDGE SYSTEMS ☞ Review of consumer complaints to improve service practices. ☞ Quality benchmarks review KNOWLEDGE SYSTEMS ☞ Review of consumer complaints to improve service practices. ☞ Quality benchmarks review	☞ Example 22: Probity Screening Recommendations, Community Services Commission of NSW. ☞ Example 23: Approaches to Child Protection Probity Screening (UK & USA). ☞ Example 17: Sanctions for Non-Compliant Residential Aged Care Services. ☞ Example 18: Charter of Residents' Rights in the Australian Commonwealth Aged Care Act. Also Appendix 1 ☞ Example 21: Complaints Resolution Scheme in Aged Care Services. ☞ Example 19: Consumer Participation in the Mental Health Sector in Victoria. ☞ Example 24: Approaches to Staff Recruitment, Qualifications and Training. ☞ Example 16: Approaches to Promoting Best Practice. ☞ Example 13: Outcomes Monitoring Project. ☞ Example 15: Proposed Quality Assurance System - Commonwealth Disability Programs. ☞ Example 26: Policy Development - Abuse Prevention in Disability Service Standards.

4. SAFER SERVICE ENVIRONMENTS

It is at the level of service delivery that the protection measures can be taken to reduce the vulnerability of people with a disability to abuse and neglect.

Features of service environments that can contribute to heightened risk of abuse, include:

- Social isolation and individual vulnerability.
- Inadequate protection of human rights and lack of choices or freedoms.
- Cultural norms are different to those of the broader community.
- Overcrowding and incompatibility between consumers and limited choices with regard to the mix of households, work colleagues or clusters of people.
- Power imbalance between consumers and staff.
- Staffing problems such as high turnover, poor skills, lack of supervision, stress and frustration.
- Consumers with complex needs and challenging behaviour.

"The main responsibility for safeguards against abuse must lie within service design and management." (Craft, in Sobsey 1994).

"Abuse prevention must begin at the earliest stages of planning of any human services" [Sobsey, 1994]

These features are complex and interrelated. Due to the diverse and complex nature of the abuse that can take place within service environments, no single risk-management approach is sufficient. A variety of safeguards and forms of protection are needed.

4.1 ORGANISATION CHANGE AND CULTURE

The culture within the organisation and the environment in which services are provided is a significant determinant in the likelihood of abuse occurring. Preventing abuse within the service setting will often require a change or process of ongoing improvement in workplace culture. Workplace cultures that are positive towards people with a disability and support their valued status, inhibit abuse and violence.

For learning and improvement to occur broadly and continuously in organisations, a range of complementary organisational values, behaviours, attitudes, structures and processes need to be present to support and encourage learning, improvement and change. Consequently, achieving quality improvement in organisations requires change to staff attitudes and behaviour. Such changes only effectively occur when organisational culture is addressed.

Culture sets the boundaries of behaviour and attitudes in an organisation, so addressing the broader cultural context is critical to success in achieving effective change and improvement. Appropriate cultural change efforts support the development of values, processes and structures that draw on the human potential of the workforce, encourage constructive questioning and innovation by staff, and emphasise continuous learning and improvement.

KP 25: WORKPLACE CULTURE WITHIN SERVICE SETTINGS SUPPORTS VALUED ATTITUDES AND CONTINUOUS LEARNING.

Organisation culture inhibits violence and abuse by supporting the valued status of people with a disability and creating positive attitudes toward service users.

4.2 TRAINING AND MANAGING SUPPORT WORKERS

"It seems clear from most of the recent literature that the key to quality hinges largely on the nature of interpersonal relationships." (Nolan, 1999).

Professional development and training are critical to the safety and well being of consumers. The literature insists that due to the high vulnerability of consumers in disability services the use of untrained workers should be considered an unacceptable management practice, particularly in residential services.

In order to provide effective support, staff require skills in areas such as communication, respect and dignity, confidentiality, effective supports, appropriate conduct, positive attitudes, and responding to individual needs. Professional development is essential to create service environments where both consumers and staff are valued and relationships are free of abuse or neglect.

Mandatory training on implementing policies on the three aspects of abuse - recognition, reporting and assisting people who have been abused - should be covered as part of staff induction practices and completed prior to any client contact. Additional training needs may include multi-disciplinary collaboration to respond to family-based abuse, and dispute and conflict resolution and anger management.

There is also broad support for mechanisms to monitor and investigate areas with high staff turnover. Unusually high staff turnover has been consistently identified as an indicator of poor service environments in which abuse is likely to occur. Contributing factors include:

- High turnover reduces attachment in relationships between caregivers and consumers.
- Inexperienced staff are more likely to be susceptible to feelings of inadequacy, stress or resentment, which can lead to abusive behaviour toward consumers.
- High turnover may indicate poor working conditions, including lack of resources, training, overburden and stress, factors that contribute to abuse and neglect.
- Staff may be leaving because they find the service environment or practices unacceptable with regard to people with a disability but feel unable to effect change.

Staff management including workload, skills mix and supervision is an important consideration in abuse prevention. Stress and frustration are common causes of physical abuse against consumers, while lack of supervision can provide increased opportunities for predatory abuse such as sexual abuse. Poor management

practice can leave consumers vulnerable to theft by inadequately protecting their belongings, finances or consumables.

Success factors in the training and management of support workers include:

- Comprehensive initial training and induction to service provision; and
- Staff development programs that integrate learning into the workplace and encourage the application of learning.

KP 26: STAFF IN DISABILITY SERVICES HAVE BASIC COMPETENCIES IN ABUSE PREVENTION.

Support Workers receive initial skills training in abuse prevention, identification and response before working with vulnerable adults.

Ongoing skills development is built into quality assurance and service monitoring.

KP 27: HUMAN RESOURCE PLANNING INCLUDES MONITORING INDICATORS AND RISKS RELATED TO ABUSE.

Significant factors such as high turnover are monitored and investigated.

Managers have sufficient expertise and experience in human resource management and are aware of the factors and signs that could indicate an increased risk of abuse.

4.3 RISK ASSESSMENT

Assessing risk within service environments is an area that has been identified in the literature as in need of further development. It has also been suggested that the capacity of programs to assess individual vulnerability to abuse might be improved by more sophisticated risk assessment tools.

Risk assessment is not currently a consistent feature of the disability services sector, unless applied to people at risk of self-harm or harming others due to challenging behaviour. Broader approaches to examining risk within the context of the service and multiple factors have not been widely developed.

Predictive risk assessment tools rely on proven models of causation and influence. Such tools and models have been successfully developed in the child protection area, but not in the disability services sector. Functional models of abuse are now emerging that may allow further development of predictive tools.

Reactive risk assessment consists of the analysis of incidence data such as critical incidents or reported theft, and/or concerns or complaints. Analysis is used to examine patterns and thereby identify risk. This is a more common form of risk assessment in service settings.

KP 28: INDIVIDUAL RISK ASSESSMENT IS INCLUDED IN INDIVIDUAL SUPPORT PLANNING.

Tools and models for predicting abuse are needed.

Individual risk assessment informs support planning.

KP 29: ENVIRONMENT RISK ASSESSMENT INFORMS SERVICE PRACTICE.

Risk assessment is linked to continuous quality improvement.

Service environment risk assessment identifies contributing factors to individual risk of abuse.

4.4 POLICIES, PROCEDURES AND CODES

The lack of clear and effective guidelines for service delivery staff to act on when confronted with abuse or potential abuse has been consistently identified as a significant factor in under-reporting and inadequate responses.

"All staff must share the responsibility for preventing abuse." (Conway et al, 1995)

Service policies and procedures should include:

- The need to include how abuse can be recognised, how abuse is to be reported and how to assist the abused person.
- The need to include neglect and unintentional neglect as types of abuse.
- Decisive disciplinary action for failure of staff to report abuse/cover up.
- Requirements for induction and in-service training in the policies and procedures.
- Clear guidelines for how to deal with allegations of misconduct or inappropriate behaviour when a staff member is suspected to be a perpetrator of abuse.

The literature advocates for sound and comprehensive policies and procedures to be readily available to all staff at all times to ensure that guidance is available when incidents of suspected or actual abuse occur. Due to the heightened risk of sexual abuse within residential services and services for people with learning disabilities, many authors recommend clear guidelines with respect to sexual activity within these service types.

CSDA jurisdictions have typically developed generic policies, procedures or guidelines related to abuse, which are provided to funded services as a basis from which to develop internal management practice.

KP 30: SERVICE MANAGEMENT INCLUDES POLICIES AND PROCEDURES RELATED TO ABUSE.

Mechanisms support services to implement policies and procedures include policy guidelines to ensure minimum prevention, identification and response standards.

KP 31: POLICY GUIDELINES RELATED TO ABUSE PREVENTION ARE DEVELOPED BASED ON GOOD PRACTICE AND ARE EVALUATED.

Policies and procedures include the identification, and response to abuse as well as codes relating to sexual conduct and consumer-to-consumer assault.

4.5 BEHAVIOUR INTERVENTION GUIDELINES

A relatively small proportion of people with a disability develop difficult or challenging behaviour, usually as a result of poor environment, life experiences, social skills, communication, or mistreatment. The presence of challenging behaviour can serve to increase the likelihood of the individual becoming a victim of abuse or potentially harming other people.

> *"One of the most complex areas in providing non abusive human services is the management of aggressive, self-injurious or disruptive behaviour… specific policies and guidelines need to be clearly defined to eliminate procedures that leave the person exhibiting the aggressive behaviour vulnerable to abuse." [Sobsey, 1994]*

There are three issues to recognise and address in relation to behaviour intervention:

1. Systemic Causes

The systemic causes of challenging behaviours are often overlooked, resulting in behaviour being viewed as an individual rather than a systemic matter. Factors that often contribute to the development of challenging behaviour include: incompatibility among residents; inappropriate staff expertise and values; lack of appropriate means of communication; lack of attention and one-to-one interaction between residents; and boredom and frustration arising from a lack of activities, external contacts and support services.

2. Positive Intervention

Effective support includes positive behaviour intervention to address behaviour that presents significant obstacles to learning or which presents potential danger to an individual or others. In particular, early intervention can prevent inappropriate behaviour escalating to the stage of significantly interfering with the well being of the individual. Strategies that equip support workers with the skills, resources and flexibility to apply positive behaviour intervention in a timely and appropriate way, can prevent abusive situations arising.

Considerable progress has been made in developing non-aversive behaviour intervention techniques. There is an extensive range of training materials available and most CSDA jurisdictions have behaviour intervention specialist support services.

3. Protection from Aversive Practices

Service systems must protect consumers with challenging behaviour from further abuse by ensuring that intervention does not involve strategies such as seclusion, restraint, medication or other forms of coercion unless it is lawfully defensible in order to prevent imminent and significant damage to the person themselves or other people. Where it is foreseen that such measures may be necessary, these practices should be subject to authorisation, monitoring and review. The implementation of safeguards has been a particular difficulty in this area; active service monitoring is required to protect consumers.

The following principles are recommended to safeguard consumers with regard to restraint and seclusion:

- Statutory authorisation for the use of restraint and seclusion in individual cases and independent monitoring and review of these practices. This includes an independent person who is required to act in the best interests of the individual client being responsible for reviewing and consenting to proposals to use restraint or seclusion.
- The statutory definitions (and accompanying approval and reporting mechanisms) for seclusion and restraint should cover all forms of these restrictive practices, such as physical restraint or when a person has been placed in a room or other area in such a way that they are unable to leave.
- There should be time limits to the amount of time that restricted practice can be used.

KP 32: THE USE OF INTRUSIVE BEHAVIOUR INTERVENTION PRACTICES IS PROHIBITED WITHOUT AUTHORISATION AND IF AUTHORISED IT IS RESTRICTED AND MONITORED.

Guidelines clearly identify unlawful acts; prohibited practices and restricted practices, including the limited circumstances in which restricted practices (including restraint) may be used and the requirements for their use including authorisation, monitoring and reporting.

Restricted behaviour intervention practices are subject to approval by an independent authorised decision-maker such as an appointed guardian.

The use of restricted practices is time-limited, regularly monitored and subject to review or appeal.

KP 33: GOOD PRACTICE IN BEHAVIOUR INTERVENTION IS PROMOTED AND RESOURCED.

Professional development in positive behaviour intervention occurs across service types.

Specialist assistance is available where required.

LINKS TO MECHANISMS AND PRACTICE EXAMPLES

KEY PRINCIPLES	MECHANISMS	PRACTICE EXAMPLES
25. Workplace culture within service settings supports valued attitudes and continuous learning. 26. Staff in disability services have basic competencies in abuse prevention. 27. Human resource planning includes monitoring indicators and risks related to abuse. 28. Individual risk assessment is included in individual support planning. 29. Environment risk assessment informs service practice. 30. Service management includes policies and procedures related to abuse. 31. Policy guidelines related to abuse prevention are developed based on good practice and are evaluated. 32. The use of intrusive behaviour intervention practices is prohibited without authorisation and if authorised it is restricted and monitored. 33. Good practice in behaviour intervention is promoted and resourced.	SAFEGUARDS & RIGHTS ☞ Guardianship mechanisms for restricted behaviour intervention ☞ Monitoring and review mechanism for restricted behaviour intervention practices ☞ Monitoring abuse indicators eg high staff turnover PARTICIPATION & COLLABORATION ☞ Specialist behaviour intervention assistance. SERVICE DELIVERY ☞ Guidelines for behaviour intervention ☞ Policies and procedures relating to abuse ☞ Service environment risk assessment ☞ Individual risk assessment AWARENESS & TRAINING ☞ Professional development in positive behaviour intervention ☞ Initial skills training in abuse prevention, identification and response before working with vulnerable adults. ☞ Management competency in human resource management KNOWLEDGE SYSTEMS ☞ Tools development	☞ Example 28: The Thanbarren Early Intervention Project. ☞ Example 27: Guidance for Codes of Conduct on Sexual Activity. (Appendices contain examples to assist the development of policies, procedures and codes.) ☞ Example 25 Model of Risk Assessment in Residential Services. ☞ Example 24: Approaches to Staff Recruitment, Qualifications and Training. ☞ Example 28: The Montreal Prevention Project . ☞ Example: 24: Handbook for Positive Behaviour Management. ☞ Example 32: Protection for People Receiving Behaviour Intervention Support. ☞ Example 31: Aged Care Restraint Policy.

5. RESPONDING TO ABUSE OR IDENTIFIED RISK

The establishment of an effective legislative and operational system for protective intervention may address some of the commonly identified barriers to reporting suspected abuse of people with disabilities. Barriers include:

- Consumers, staff and others not knowing who to report to.
- People with a disability lacking confidence that they will be believed particularly if they have a communication or cognitive impairment.
- Fear of retribution, repercussions or retaliatory action.
- Failure to recognise the difference between appropriate and inappropriate treatment.
- Lacking confidence in the capacity of the 'system' to respond to the abuse.
- Lack of training on how to identify the signs of abuse and neglect and what constitutes reportable abuse/neglect.
- Privacy and confidentiality concerns, particularly in family settings.
- Seen as pointless if there are no services and resources available to help the victim or fears that reporting will lead to further harm to the victim.
- Police and criminal justice personnel lacking skills and strategies to respond to situations of abuse against people with a disability.
- The lack of cross-sector collaboration and coordinated response.
- A lack of adequate supports for victims of abuse who have a disability and for offenders who have a disability.

5.1 RECOGNITION AND REPORTING

The absence of clear procedures for reporting abuse and strong reinforcement of such procedures by management, have each been identified as factors that can lead to insufficient attention being given to indications of possible abuse.

Directions for responding immediately and appropriately to incidents, allegations or suspicions of abuse need to be readily available and at-hand. Systematic approaches to improving response have been developed overseas. Streamlining the process and reducing the complexity of reporting mechanisms and decision-making can improve response.

Many crimes never come to the attention of the police. An Australian study found that 40% of crimes against people with mild or moderate mental retardation went unreported to the police, and 71% of crimes against people with more severe disability went unreported.

Mechanisms to increase the rate of reporting of abuse of people with disabilities need to be accompanied by mechanisms for

"The police are currently playing the role of 'gatekeepers' to justice, by exercising discretion to screen cases from coming to the attention of the courts. In effect the police are in a position to prevent the court and legal system from perceiving the need for reform of the judicial system to ensure justice for those who are most vulnerable to victimisation." (The Roeher Institute, 1993)

investigation and provision of protective responses and cross-sector collaboration with other relevant agencies if they are to be effective.

KP 34: THE RECOGNITION AND REPORTING OF ABUSE AND NEGLECT IS SUPPORTED BY CLEAR PROCEDURES OPERATING AT INDIVIDUAL, SERVICE AGENCY AND GOVERNMENT JURISDICTION LEVELS.

Systematic approaches to responding to incidents are tailored to local contexts with cross-sector collaboration to improve law enforcement and criminal justice responses.

5.2 VULNERABLE ADULT PROTECTION

Protective intervention for people with a disability who are victims of abuse or at risk of abuse involves disability support services, justice and law enforcement services and the broad range of services that support victims of crime or violence.

In the United States of America (USA), Canada and the United Kingdom (UK) cross-sector approaches to protective intervention have been established for vulnerable adults. These approaches seek to protect people at risk due to disability, reliance on services, age, competency or poor health. In some cases these interventions are combined with those for vulnerable children, in other cases they stand-alone.

One of the difficulties in such legislation is the definition of a 'vulnerable adult'. The broad definition referred to in the 1997 consultation paper "Who Decides?" (Issued by the UK Lord Chancellor's Department) is a person *"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."*

Three significant characteristics of protective systems that deserve particular attention are involuntary protection, mandatory reporting and protecting whistleblowers. Each of these has been examined in the literature review.

Involuntary protection services in the USA are interventions initiated without the consent of the affected adult, for the purpose of safeguarding the vulnerable adult who is at risk of abuse, neglect or exploitation. These situations are typically emergencies. Concerns regarding the threat to individual rights prompted research that has found less than 10% of interventions are involuntary and steps are taken to protect individual rights in those cases.

In Australia guardianship is the primary mechanism for protecting adults who are unable to make an informed decision and require a substitute decision-maker.

Typically there is a far greater outcry when APS does not intervene involuntarily in endangering situations at the urging of family, the public, and the medical community, than there is concern about unwarranted or inappropriate involuntary intervention. (Duke, 1997).

Research into mandatory reporting suggest that there is widespread agreement that mandatory reporting with regard to the abuse or neglect of vulnerable adults is necessary in institutional settings, but there is considerable disagreement on its appropriateness for non-institutional settings. Mandatory reporting typically relates to reporting incidents to the police and/or regulatory authorities with clear guidelines for circumstances under which

incidents are reported to the relevant agencies. Some Canadian and USA jurisdictions have introduced mandatory reporting in non-institutional settings while others have voluntary reporting requirements.

Protecting whistleblowers is an important element in protective intervention. Legislative protection against retaliatory action or damages action (e.g. defamation) is common in international systems and in other human service sectors in Australia.

KP 35: PROVIDE EFFECTIVE PROTECTION FOR VULNERABLE ADULTS.

Holistic approaches to adult protection are developed in collaboration with service providers, consumers and other relevant agencies.

KP 36: CONSUMERS UNABLE TO MAKE INFORMED DECISIONS AND AT RISK OF ABUSE, NEGLECT OR SELF HARM ARE APPOINTED LEGAL GUARDIANS.

Specific legislation regarding guardianship for people, who are found to be unable to make informed decisions, and require a substitute decision-maker, provides a basis for the protection of the rights of people who may be particularly vulnerable to abuse in service systems.

A service provider acting as a default decision-maker is not an effective mechanism to protect individuals from abuse, substitute decision-makers should be independent of the service system.

KP 37: PROTECT ANYONE WHO REPORTS ABUSE OR NEGLECT FROM RETRIBUTION.

Whistleblowers require protection from retribution including loss of services or employment and civil action if the abuse is unproven.

5.3 COORDINATED INTERAGENCY RESPONSE

The need for inter-agency coordination when dealing with abuse notification and management has been recognised in Australian and international jurisdictions and more broadly in the body of research. Success factors include collaboration between agencies including social service providers, law enforcement, justice, victim support services and the effective function of inter-disciplinary teams. Collaboration needs to occur at local level but requires support from all levels of the relevant agencies. Strategies to facilitate collaboration include the development of protocols and resources for interagency initiatives.

"The legal service provider for the elderly must be connected to service providers, police officers, clergy, medical providers and others who are traditionally called upon to serve in the multi-disciplinary approach to problem solving for the elderly. The solutions to elder abuse most often do not result from legal processes but from coordinated community response." (Levitt & O'Neil, 1997).

In other countries the coordination of a range of activities related to abuse prevention and responding to abuse have been based around a population or type of abuse. For example the USA Administration on Ageing coordinates activities nationally and through State based organisations, to address elder abuse.

KP 38: THERE IS A COORDINATED INTERAGENCY RESPONSE TO ABUSE AND NEGLECT.

Interagency protocols are developed and adopted at the local level.

Joint training initiatives allow cross-sector skills development.

5.4 SUPPORTING VICTIMS OF ABUSE

Abuse may continue or the impact of abuse may be exacerbated by a lack of access to appropriate support services for victims. For example research in the USA and Canada has found that inadequate access to services that assist women to escape domestic violence is a primary factor in women with a physical disability remaining in abusive situations longer than women without a disability. The need for access to supports (including transport and alternative accommodation) to escape abusive situations and counselling to address the harm caused by abuse applies not only to women with a disability but also to men, children and young people. Individuals can also experience compounded disadvantage caused by factors such as geographic or social isolation, communication or language difficulties etc.

This calls for action to make all programs for victims of abuse fully accessible, and all disability service programs equipped to identify abuse and refer individuals to appropriate services. This can be extended to the needs of people with a diverse range of disabilities and the need for services at a local level to have the capacity to respond. The Disability Discrimination legislation in place in all Australian jurisdictions is a significant driving force in achieving accessibility, however there is no evidence to demonstrate that the accessibility of such services in Australia has been systematically assessed.

KP 39: SERVICES THAT ASSIST VICTIMS OF ABUSE TO ESCAPE AND RECOVER FROM ABUSE ARE ACCESSIBLE TO ADULTS AND CHILDREN WITH A DISABILITY.

Within communities defined by area or population there needs to be adequate capacity to respond to the diverse needs of people with a disability escaping violent or abusive situations.

5.5 CRIMINAL JUSTICE ISSUES

People with a disability have poor access to the justice system. Barriers include the lack of physical and social access to the courts, rules of evidence, and courtroom procedures that unfairly impinge on the rights of people with a disability. The lack of involvement with the police and the criminal justice system in situations of abuse of people with a disability can be due to concerns such as belief that there is insufficient evidence for prosecution; the view that the victim will not be capable of standing up to cross-examination; and concerns about the incarceration of people with an intellectual disability (where they are the perpetrator).

The responsibility for reform in the criminal justice system lies outside of the CSDA jurisdictions. However, cross-sector approaches to developing support programs for people with a disability have significant potential benefit for reducing repeat offending and supporting both people who have assaulted others and people who have been the victims of assault. Strategies for improving access to justice include:

- Addressing barriers to people with a disability giving evidence, including increased support in communication and the processes of the justice system.
- Providing advocacy support to people with a disability within the criminal justice system.

- Diversion and intervention programs for people with a disability that are in contact with the criminal justice system.

Component 2.2 Advocacy refers to access to advocates for people with a disability within the criminal justice system.

KP 40: COLLABORATE WITH THE CRIMINAL JUSTICE SYSTEM TO PROVIDE ACCESS FOR PEOPLE WITH A DISABILITY.

There is specific training for police, justice personnel and for disability service staff.

Advocates are available to people with a disability in contact with the criminal justice system

KP 41: SUPPORT SERVICES WORK LOCALLY WITH THE CRIMINAL JUSTICE SYSTEM TO ASSIST OFFENDERS WHO HAVE A DISABILITY AND REDUCE REPEAT OFFENDING.

Services provide and participate in diversion and intervention programs and initiatives.

5.6 COMMUNITY-BASED CRIME PREVENTION

Crime prevention encompasses a broad approach to programs and other interventions that focus on changing the social conditions, environment or patterns of behaviour or institutions that influence offending. Community-based approaches are of particular relevance to communities where isolation may be geographic, cultural or socioeconomic.

A community-based crime prevention approach involves strong collaboration between agencies responsible for disability services and other government departments such as those responsible for justice, law enforcement, young people and children. Significant partners in these approaches would include the National Crime Prevention Strategy and the National Centre for Criminology.

In order to identify appropriate strategies for crime prevention data needs to be collected on crime committed against the defined population or group.

Currently disability is not identified in Australian crime statistics and disability services do not consistently report crime against people they support including abuse or neglect. The USA government recognised the need to better identify victims of crime who have a disability, in order to raise community awareness and develop appropriate community responses. This resulted in the Crime Victims with Disabilities Act (USA) (see example in Knowledge Systems Mechanism Section). Consistent data collection of abuse, neglect and crime would assist the development of prevention approaches.

KP 42: AS FAR AS POSSIBLE AND WITH RESPECT TO INDIVIDUAL RIGHTS OF DISCLOSURE, GENERIC COMMUNITY SERVICE AGENCIES (INCLUDING THE POLICE, THE HEALTH SECTOR AND VICTIM SUPPORT SERVICES) COLLECT DATA ON THE ABUSE, NEGLECT AND CRIME AGAINST PEOPLE WITH A DISABILITY.

Understanding the causal relationships between vulnerability to abuse and neglect and disability can be enhanced through data collection and analysis; this may also serve to raise awareness.

Crime prevention strategies may be appropriately applied within service settings or with populations of people supported in the community; more assistance may be required for services to implement strategies of this nature starting with sound data regarding incidence and patterns.

LINKS TO MECHANISMS AND PRACTICE EXAMPLES

KEY PRINCIPLES	MECHANISMS	EXAMPLES
34. The recognition and reporting of abuse and neglect is supported by clear procedures operating at individual, service agency and government jurisdiction levels. 35. Provide effective protection for vulnerable adults. 36. Consumers unable to make informed decisions and at risk of abuse, neglect or self harm are appointed legal guardians. 37. Protect anyone who reports abuse or neglect from retribution. 38. There is a coordinated interagency response to abuse and neglect. 39. Services that assist victims of abuse to escape and recover from abuse are accessible to adults and children with a disability. 40. Collaborate with the criminal justice system to provide access for people with a disability. 41. Support services work locally with the criminal justice system to assist offenders who have a disability and reduce repeat offending. *42.* As far as possible and with respect to individual rights of disclosure, generic community service agencies (including the police, the health sector and victim support services) collect data on the abuse, neglect and crime against people with a disability.	SAFEGUARDS & RIGHTS ➔ Specific legislation regarding guardianship. ➔ Whistleblowers protection ➔ Holistic approaches to adult protection PARTICIPATION & COLLABORATION ☞ Systematic approaches to responding to incidents of abuse ☞ Interagency protocols are developed and adopted at the local level. ☞ Capacity to respond to the diverse needs of people with a disability escaping violent or abusive situations. ☞ Advocates are available to people with a disability in contact with the criminal justice system SERVICE DELIVERY ☞ Services provide and participate in diversion and intervention programs and initiatives. AWARENESS & TRAINING ☞ There is specific training for police, justice personnel and for disability service staff. ☞ Joint training initiatives allow cross-sector skills development. KNOWLEDGE SYSTEMS ☞ Crime prevention strategies may be appropriately applied within service settings or with populations of people supported in the community.	☞ Example 33 The Development of 'Vulnerable Adult' Legislation. ☞ Example 34: Adult Protective Services in the USA. ☞ Example 39: Criminal Justice Initiatives in Western Australia. ☞ Example 38: Guidance to Develop Interagency Protocols. ☞ Example 45: The Children at Risk Program. ☞ Example 42: Community Based Sexual Abuse Response Team in Aboriginal Communities. ☞ Example 37: Regional Violence Prevention Specialists. ☞ Example 40: Crime Victims with Disabilities Awareness Act (USA).

6. ADDITIONAL CONSIDERATIONS FOR SPECIFIC POPULATIONS

Throughout this Framework the term 'people with a disability' has encompassed the population of people with a disability in the broadest sense, including children, young people, adults and older people; as well as indigenous people and individuals from diverse cultural backgrounds. However, the experiences of some groups are characterised by factors substantially different to the broader population and require additional consideration.

This Framework has been developed for broad application and is not able to fully address the specific needs of all groups who might benefit from additional consideration. The following groups were identified as requiring additional consideration; preliminary discussion is provided to prompt further work in this area.

6.1 ABORIGINAL AND TORRES STRAIT ISLANDERS

6.2 DIVERSE CULTURE AND LANGUAGE GROUPS

6.3 CHILDREN WITH A DISABILITY

6.1 ABORIGINAL AND TORRES STRAIT ISLANDERS

The Australian research literature examining the abuse of people with a disability, contains limited discussion regarding the circumstances and experiences of Aboriginal and Torres Strait Islanders within this population. There is some work undertaken with indigenous communities available from overseas. This work is not readily transferable to the Australian context but highlights the significance of culture and community life in understanding, preventing and responding to abuse appropriately.

Further research and consultation with the Aboriginal and Torres Strait Islander community is needed to identify all of the specific considerations that would be relevant to the application of this Framework for this population. Examples of likely considerations are provided below. This list is neither comprehensive nor exclusive.

Figure 4: Example of Considerations for Indigenous Populations

COMPONENT	CONSIDERATIONS
UNDERSTANDING ABUSE	Recognition of cultural differences in areas fundamental to the understanding of abuse (for example: power within relationships, community response to disability and violence). Social issues within indigenous communities such as drug and alcohol addiction, youth unemployment, disenfranchised and fragmented families, are each likely to impact on the patterns and causes of abuse, the incidence and the development of prevention strategies.
PRIMARY PREVENTION	Social integration and separation issues are likely to be different to those of the non-indigenous community. Participation in employment and economic independence are also likely to require specific attention.

COMPONENT	CONSIDERATIONS
	The need to improve access to advocacy services for indigenous people with a disability has been identified in the Review of the National Advocacy Program. The benefit of collaboration with family support services applies also to these and other social support services provided to indigenous families and communities.
PREVENTING SYSTEMS ABUSE	There are specific issues concerning access to services to supports, tailored approaches to the needs of individuals, families and populations, developing appropriate evaluation processes and consumer participation.
SAFER SERVICE ENVIRONMENTS	Across the range of service operations such as risk assessment and staff training, there is need for cultural sensitivity and understanding systemic societal influence on individual experience.
RESPONDING TO ABUSE OR IDENTIFIED RISK	Tensions between indigenous communities, law enforcement and legal systems are significant factors in developing appropriate approaches to responding to abuse, supporting victims and preventing repeat offending. Indigenous services, including criminal justice and legal representation services need to be included when developing interagency responses to abuse.

Across a range of human service sectors (including children's services, family support services, health and education etc), there is recognition of the need to increase access to social supports for people who are Aboriginal or Torres Strait Islander through the development of culturally-specific services. This can occur through resourcing the Aboriginal community to provide services or increasing the involvement of the Aboriginal community at all levels of decision-making and service operation. Such action may itself significantly impact on the patterns and causes of abuse for indigenous people with a disability. There are also considerations with regard to how abuse prevention within culturally-specific services might be informed by research conducted in mainstream service settings.

See also *Component 2.2: Advocacy*.

KP 43: PREVENTING ABUSE IS INCORPORATED IN THE DEVELOPMENT OF CULTURALLY APPROPRIATE SERVICES (GENERIC AND SPECIFIC) FOR ABORIGINAL OR TORRES STRAIT ISLANDER PEOPLE WITH A DISABILITY.

Further research and consultation with indigenous people, communities and service providers is needed to improve understanding with regard to abuse and to identify appropriate prevention strategies.

6.2 DIVERSE CULTURE AND LANGUAGE GROUPS

Equity in access to services and the provision of culturally appropriate supports for people from non-English speaking or culturally diverse backgrounds, is an area requiring ongoing quality improvement and is included in the national Disability Service Standards.

Research and development related to the abuse of people with a disability rarely identifies culture or language groups within this population. There is therefore little guidance in established work for developing culturally appropriate prevention strategies, or recognising the impact of diversity on the implementation of strategies.

The potential for culture or language difference to affect an individual's vulnerability to abuse may be inferred from other research findings in some areas. For example: limited communication increases the likelihood of abuse, therefore poor skills in English and limited access to first language interpreters may be considered a risk factor; cultural beliefs or experiences such as trauma or separation from family may also impact on risk. Other considerations are not as easily identified and require further development. Some considerations are suggested in the table below. Once again these are not intended to be comprehensive or exclusive.

Figure 5: Example of Considerations for Cultural and Linguistic Groups

COMPONENT	CONSIDERATIONS
UNDERSTANDING ABUSE	Identify and acknowledge the impact of culture, language and individual experiences (such as trauma or separation from family) on aspects of service delivery that are known to be related to abuse. For example: relationships with providers, expectations from service systems, capacity to identify and report abuse.
PRIMARY PREVENTION	Cultural responses to disability can vary and may impact on activities such as increasing the valued status of people with a disability in the community. There is a need to recognise this diversity and develop appropriate strategies.
PREVENTING SYSTEMS ABUSE	There are specific issues concerning access to services and supports, tailored approaches to the needs of individuals, families and populations, developing appropriate evaluation processes and consumer participation.
SAFER SERVICE ENVIRONMENTS	Across the range of service operations such as risk assessment and staff training, there is need for cultural sensitivity and recognition of the impact of culture and language in areas such as communication, relationships with carers and access to advocates.
RESPONDING TO ABUSE OR IDENTIFIED RISK	Cultural beliefs or individual experiences of other societal norms may be a significant factor in reporting abuse, particularly with regard to the involvement of agencies such as the Police or health professionals. Collaborative responses to abuse need to be flexible to respond to individual cultural or language needs.

KP 44: QUALITY ASSURANCE AND ABUSE PREVENTION APPROACHES DEVELOP WITH CONSIDERATION TO CULTURAL AND LINGUISTIC DIVERSITY.

In-depth analysis and consultation with specific culture and language groups is needed to further develop the specific considerations relevant to abuse prevention.

Australian research into abuse within disability services should examine the impact of population diversity.

6.3 CHILDREN WITH A DISABILITY

"Disabled and non disabled children alike are victim to power dynamics operating in society, and particularly the inequities found in abusive relationships. However, children with disabilities are extra vulnerable as a result of being seen as "different" and treated in ways not experienced by their non disabled peers." (Westcott, 1993 cited in Sobsey, 1994)

The lives of children are very different to those of adults. Particular issues to consider include:

- The legislative protection frameworks governing children are quite different to those of adults.
- The family and school environment, parental control and relationships with siblings and peers are of particular significance in the lives of children.
- Working with children and families, particularly to strengthen families and reduce propensity for violence, is an area that requires specialist skills from across a range of disciplines.

Children who have a disability are children first; their disability is not their primary identification. The responsibility for preventing their abuse is therefore part of the broader community and government commitment to child protection.

The interface between children's services/child protection and disability services is however significant to the effectiveness of prevention approaches. Strategies to prevent the abuse of children with a disability include collaboration to achieve the following:

- Access to **services and supports** for children, families and siblings including generic and specialist assistance.
- **Inclusive education** and **self-protection programs** in schools that are adapted to the specific needs of children with a disability, across the range of disability types and other characteristics including cultural background.
- Societal and community based strategies to **strengthen families and communities** (including school communities), promote healthy attitudes and build resilience to violence and abuse.
- **Multi-disciplinary approaches** to intervention in response to identified risk or abuse.
- **Cross-sector training** to build disability skills in children's services and child protection skills in disability services.

KP 45: DISABILITY AND CHILDREN'S SERVICE SECTORS COLLABORATE TO PROTECT CHILDREN WITH A DISABILITY FROM ABUSE.

Collaboration to protect children includes multi-disciplinary approaches, shared knowledge and cooperation across education, family services, children's services child protection and law enforcement services.

Child protection agencies work with children who have a disability and have experienced or are at risk of experiencing abuse or neglect, within disability service settings and/or within the family setting.

The Disability Discrimination Act is implemented within child protection services.

KEY PRINCIPLES	MECHANISMS	EXAMPLES
43. Preventing abuse is incorporated in the development of culturally appropriate services (generic and specific) for Aboriginal or Torres Strait Islander people with a disability. 44. Quality assurance and abuse prevention approaches develop with consideration to cultural and linguistic diversity. *45.* Disability and children's service sectors collaborate to protect children with a disability from abuse.	SAFEGUARDS & RIGHTS ☞ Children with a disability are adequately protected by legislation and procedures that apply to all children's services. SERVICE DELIVERY ☞ Services provided to indigenous people and people from diverse cultural backgrounds, address additional risk factors relevant to abuse. ☞ Services provided to children address unique risk factors in relation to abuse. AWARENESS & TRAINING ☞ Disability support providers have awareness and skills in issues related to abuse across specific populations. KNOWLEDGE SYSTEMS ☞ The effectiveness of abuse prevention strategies is measured across population groups. ☞ Research informs the development of abuse prevention strategies appropriate to specific populations.	☞ Example 42: Community Based Sexual Abuse Response – Aboriginal Communities. ☞ Examples 43: Oregan Social Learning Centre Parent Training. ☞ Example 44: Child Abuse Prevention Teams. ☞ Example 45: The Children at Risk Program in Connecticut.

Section B: Framework Mechanisms

This section of the Framework describes at a more practical level the mechanisms and examples of practice that may assist the implementation of key principles identified in Section A.

The mechanisms are not intended as a prescriptive recipe for prevention of abuse. Instead, they are described in terms of broad approaches and critical success factors. Examples of practice are referred to by number and title. The examples are described in Section C of this Framework.

The following categories of mechanisms are described:

- SAFEGUARDS AND RIGHTS
- PARTICIPATION AND COLLABORATION
- SERVICE DELIVERY
- AWARENESS AND TRAINING
- KNOWLEDGE SYSTEMS

The examples are given to assist the development of tailored approaches suitable to local contexts. It is anticipated that tailored approaches would be developed with collaboration and consultation with stakeholders, as well as consideration of existing frameworks and processes.

Providing quality services and preventing the abuse of people with a disability should be an area of continuous improvement and no single or holistic approach could be considered 'best practice' or appropriate to all jurisdictions and circumstances. Therefore examples of practice have been selected on the basis of one or more of the following criteria:

- Consistent with the elements of 'good practice' described in the literature.
- Demonstrated value through evaluation.
- Innovative practice developed from research and analysis.
- Demonstrates application in unusual or diverse contexts.

SAFEGUARDS & RIGHTS

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
ACTS AND REGULATIONS	☑ Protection against abuse applies to service settings, home or family settings and community environments. ☑ Guardians can be independently appointed when a person with a disability is unable to make significant life decisions, is at risk of abuse or demonstrates challenging behaviour requiring intrusive intervention. ☑ Regulations governing funded services prohibit and restrict the use of intrusive or restrictive behaviour management practices including seclusion and physical or chemical restraint. Legislation restricts the use of specific interventions to be used only with guardian authorisation. ☑ Sanctions can be made against services and individuals found to perpetrate abuse or neglect against a person or persons who have a disability and/or services found to breach minimum standards of quality.	☞ The WA Disability Services Act 1993 (section 53) makes an offence of ill treatment. A person who ill-treats or wilfully neglects a person with a disability while that person is under his or her care, supervision or authority commits an offence. ☞ The VIC Intellectually Disabled Persons Services Act outlines provisions for a statement of rights to be provided to persons upon admission to a service. ☞ The majority of State/Territory jurisdictions in Australia have Guardianship legislation in place. ☞ The active involvement an appointment of Guardians in addressing challenging behaviour requires further research.
PROBITY SCREENING AND RECRUITMENT PRACTICE	☑ High standards of integrity are established for people working in the disability services sector, due to the vulnerability of this population. ☑ Service providers routinely screen all staff and adopt good recruitment practice. ☑ Central information is maintained regarding incidents of abuse that have not led to criminal charges or prosecution.	☞ Example 22: Recommendations for Probity Screening in Disability Services (NSW) ☞ Example 23: Approaches to Child Protection Probity Screening.

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
WHISTLEBLOWER PROTECTION	☑ People who report abuse against a person with a disability are protected against retribution or reprisal, including protection from defamation or other civil proceedings as a result of making the report, and protecting the identity of the person.	☞ The QLD Whistleblowers Protection Act 1994 allows 'anybody' to make a disclosure about a 'substantial and specific danger to the health or safety of a person with a disability' and be covered by the special protection for public interest disclosures. This protection includes not being liable, civilly, criminally or under an administrative process, for making a disclosure; and making unlawful any reprisals or detrimental action taken against a person making a public interest disclosure. ☞ The NSW Community Services (Complaints, Reviews and Monitoring) Act includes a clause that makes it an offence for any person to take or threaten to take 'detrimental action' against a person who has made a complaint, or provided information to the Commission.
ADULT PROTECTIVE SERVICES	☑ Strongly linked mechanisms to ensure that the rights of individuals are protected and that intervention can occur when there is evidence of abuse or neglect. ☑ Elements of an adult protection system include definition of the population; identification of safeguards; determination of when to intervene; establishment of intervention mechanisms; coordination of interagency responses; and protection for whistleblowers. ☑ Systematic approaches to adult protection typically apply across a broad range of circumstances including in family, community and a diversity of service settings. ☑ A collaborative approach to the protection of people with a disability, young people in care, older people and people with a mental illness may assist the development of more comprehensive protections for adults.	☞ The USA National Association of Adult Protective Services Administrators (NAAPSA) has developed *Ethical Principles and Best Practice Guidelines for Adult Protective Services*. Copies can be obtained from http://www.elderabusecenter.org ☞ Example 33: Development Of 'Vulnerable Adult' Legislation in the UK ☞ Example 34: Adult Protective Services in the USA

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
INDEPENDENT MONITORING AND COMPLAINTS AGENCIES	☑ Independent monitoring and complaints agencies have a range of legislative powers and functions that are complementary to handling individual complaints. These agencies: o Have the capacity to undertake monitoring within the service setting through visits to the services. o Develop effective mechanisms to promote the flow of information. o Have adequate resources for investigating, reviewing and responding to individual complaints. o Adopt an active, structured approach to facilitating systemic improvements through the review and analysis of patterns of complaints and effective approaches to addressing issues. o Handle complaints in accordance with the Australian Standard AS4269 1995 for complaints handling processes. ☑ There is high awareness of complaints agencies among services users and other relevant populations eg carers, advocates. ☑ Complaints mechanisms are accessible to people with a disability, including people who are socially isolated within service systems. ☑ Complaints can be confidential and anonymous.	☞ Examples of complaints and monitoring mechanisms in Australian CSDA jurisdictions, that are independent from funding agencies, include: • ACT Community and Health Services Complaints Unit; • NSW Community Services Commission; • NT Health and Community Services Complaints Commission; • TAS Health Complaints Commission; and the • WA Office of Health Review. State/Territory CSDA jurisdictions also list Ombudsmen and Public or Community Advocates. ☞ Example 18: Charter of Residents' Rights in the Commonwealth Aged Care Act ☞ Example 30: Protection for People Receiving Behaviour Intervention (VIC) ☞ Example 17: Sanctions for Non-compliant Services Department of Health and Aged Care ☞ Example 21: Complaints Resolution Scheme, Department of Health and Aged Care ☞ Example 5: The Community Visitors Scheme of the Community Services Commission of NSW

PARTICIPATION AND COLLABORATION

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
CONSUMER PARTICIPATION	☑ Individual and collective advocacy operates to protect the rights of consumers within service systems and to address systemic barriers to social participation. ☑ Consumer participation in quality assurance is built into quality assurance systems and supported by government through the provision of independent assistance to consumers and consumer training. ☑ Advocates are available to people who have experienced abuse, are at risk of abuse, or where people with a disability are offenders and may be involved in the criminal justice system. ☑ People with a disability are represented at all levels of decision-making and are able to influence the way in which services are provided.	☞ Example 11: Consumer Participation In Victorian Mental Health Sector ☞ Example 20: Consumer Participation in the Commonwealth Quality Assurance System
CROSS-SECTOR COLLABORATION	☑ Effective linking between specialist disability services and generic family and children's services including child protection intervention services. ☑ Interagency coordination with criminal justice and law enforcement agencies. ☑ Access for people with a disability to mental health services where appropriate. ☑ Promoting integration through school education and children's services, employment and work opportunities and access to community facilities and services.	☞ Example 38: Guidance to Develop Interagency Protocols from the UK Department of Health ☞ Example 45: Children at Risk Program in Connecticut, USA ☞ Example 37: Regional Violence Prevention Specialists in NSW ☞ Example 42: Community Based Sexual Abuse Response Team In Aboriginal Communities, Canada
CROSS-GOVERNMENT COLLABORATION	☑ Consistent language in abuse prevention. ☑ Diversion programs for people with a disability in the criminal justice system. ☑ The application of crime prevention approaches to ending abuse, including the identification of crimes against people with a disability, community-based approaches and the application of prevention models within service systems.	☞ Example 3: Strategies to Raise Awareness - National Child Protection Council Prevention Strategy For Child Abuse, Australia ☞ Example 39: Criminal Justice Initiatives in Western Australia

SERVICE SYSTEMS

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
POLICY RESOURCES AND GUIDELINES	☑ The need to include how abuse can be recognised, how abuse is to be reported and how to assist the abused person in the short term and the longer term. ☑ Broad explanations of abuse in addition to examples of the diversity of types of abuse that can occur singly and in combination. Examples should include neglect and unintentional neglect as types of abuse. ☑ Clear guidelines for how to deal with allegations of misconduct or inappropriate behaviour when a staff member is suspected to be a perpetrator of abuse. ☑ People with learning disabilities and people who live in residential service settings are particularly vulnerable to sexual abuse. Various studies have recommended clear guidelines with respect to sexual activity within residential service settings. ☑ The implementation of policies and procedures should incorporate: ☑ That policies and procedures are accessible and understood by all staff, families and support personnel, including volunteers. ☑ Provide for decisive disciplinary action for failure of staff to report abuse/cover up. ☑ Requirements for induction and in-service training in the policies and procedures.	☞ The Department of Health and Aged Care Code of Conduct and Ethical Practice Working Group has developed the draft Code of Conduct and Ethical Practice. The Code aims to assist partners in the aged care sector to work in a professional and ethical manner and to raise community confidence in the aged care industry. ☞ The Ageing and Disability Department in NSW is developing a policy and guidelines on preventing and responding to abuse and assault in disability services, to provide a framework for: • The prevention of abuse and assault and to minimise the severity of incidents; • Appropriate, timely and coordinated response by mainstream and specialist disability agencies; and • Follow-up and evaluation (to ensure that response plans are implemented and to inform future practice). This policy will be tested and evaluated before full implementation. ☞ Example 27: Guidance On Developing Codes Of Conduct On Sexual Activity, Department of Health, UK ☞ Example 32: Ageing And Disability Department Handbook For Positive Behaviour Management

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
ACCESS AND COORDINATION	☑ Funding agencies allocate resources based on individual needs. ☑ Decisions regarding priority access to supports and services are defensible and based on assessment of need and risk. ☑ Services provide individually tailored and flexible supports. ☑ People with a disability are assisted to access to generic and specialist supports and a variety of service options. ☑ Services are coordinated at the local level.	☞ The Productivity Commission (2000) identified Western Australia as having high consumer satisfaction with regard to service coordination. Western Australia has established the Disability Services Commission across the state to coordinate access to mainstream and specialist services. ☞ Example 9: Disability Services Access System in NSW ☞ Example 10: Local Area Coordination ☞ Example 11: Service Coordination in Aged Care, Australia ☞ Example 26: Model Of Risk Assessment In Residential Services (NSW)
QUALITY ASSURANCE	☑ Funding decisions are linked to service monitoring and individual needs assessment. ☑ Only services meeting quality standards are eligible to provide services. ☑ Quality standards protect consumers from abuse and neglect. ☑ Consumers have confidence in quality systems. ☑ Staff training is built into quality assurance and service monitoring.	☞ Examples 14: Broad Approaches to Quality Assurance ☞ Example15: Proposed Quality Assurance System in Commonwealth Disability Programs, Australia ☞ Example 16: Approaches to Promoting Best Practice ☞ Example 26: Policy Development - Abuse Prevention in Disability Service Standards

AWARENESS AND TRAINING

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
INFORMATION AND TRAINING FOR PEOPLE WITH A DISABILITY	☑ The coordination of CSDA resources for building the resilience of people with a disability to abuse is coordinated across jurisdictions to avoid duplication and increase access (eg national register) ☑ Ensuring that there is access to training, particularly training for people who are at risk of abuse, in isolated communities (due to geography or language/culture). ☑ Trainers who are skilled in training people with a disability are available for resilience building programs. This has been addressed in others sectors by working with the vocational education and training sector to promote professional development opportunities in this area. ☑ Children with a disability are provided with self-protection training in schools that is equivalent to that of the broader population of children, but adapted where necessary for the specific needs related to disability, life experiences and cultural background.	☞ A statement or charter of consumer rights (see Example 1) can be a powerful statement of government commitment to consumer rights within service systems. It can also provide guidance to service providers and direct support workers with regard to their relationship to consumers. The effective use and distribution of a charter or statement can serve to inform consumers of their rights and improve access to support mechanisms such as advocacy or representation when individual rights are at risk. ☞ Example 28: The Thanbarran Project (Early Intervention), ACT ☞ Example 29: The Montreal Prevention Project
COMMUNITY EDUCATION	☑ Educating the public about the serious nature and effects of abuse and neglect of people with a disability; also the diversity of factors which precipitate abuse and neglect and helping people learn to recognise the indicators. ☑ Publicising materials in other languages based on the linguistic composition of the community. ☑ Address stereotypic and negative attitudes toward disability. ☑ Work with school students to develop positive images of people with a disability through inclusive education and training programs. ☑ Meeting the education, training and support needs for parents. ☑ Children with a disability are promoted as children first and valued members of the community in the same way that other children are valued.	☞ Building on the experiences in the National Mental Health Strategy, promotion activities to change community attitudes toward disability and prevent abuse may be best targeted at a local level through service providers and peak groups representing people with a disability. These activities are unlikely to be a priority for service providers unless adequately resourced and supported at a National or State/Territory level including funding, materials and advice. ☞ Example 4: Community Awareness Program - National Mental Health Strategy Evaluation ☞ Example 43: Oregon Social Learning Centre Parent Training Programs

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
PROFESSIONAL DEVELOPMENT FOR THE DISABILITY SERVICE SECTOR	☑ Recognising abuse, reporting and responding and working with other agencies including police, criminal justice personnel, crisis and assault services. In particular, the need for careful observation of individual wellbeing and behaviour to recognise indicators of abuse, such as increased self-neglect or aggressive behaviour, unexplained injury, and changes in psycho-social behaviour. ☑ Support workers recognise when a consumer may need a guardian or advocate, arranging access to relevant organisations and working collaboratively with guardians and advocates. ☑ Support workers receive training in positive behaviour intervention and have awareness of prohibited or restricted practices. ☑ Build technical skills in areas such as providing support with financial management, self protective behaviours, increasing self esteem and using creative communication and technology including facilitated communication, nonverbal communication etc, as well as avoiding practices that teach over-compliance or increase vulnerability. ☑ Disability services working with children ensure that staff receive child protection training and are competent to work with children and their families.	☞ Example 24: Approaches to Staff Recruitment, Qualifications and Training, Australia
PROFESSIONAL DEVELOPMENT IN OTHER SECTORS	☑ Training for police to improve responses to people with a disability as both victims and offenders, including increasing access to the criminal justice system in both cases. ☑ Training for criminal justice personnel to respond to people with a disability as witnesses and as offenders. Skills of health providers and investigators in communicating with people with a disability and using assessment tools developed for this population. ☑ Training for sexual assault counsellors and crisis centres to be accessible for people with a disability. ☑ School teachers and other professionals prevent children with a disability becoming over-compliant and teach self protective behaviour. ☑ Training to ensure that children with a disability require the same access to child protection and intervention services as other children.	☞ Women with Disabilities Australia produced 'More than Just a Ramp: A Guide for Women's Refuges to Develop Disability Discrimination Act Action Plans' in 1997. The Guide is available from WWDA, visit their web site: www.wwda.org.au for more information. ☞ The USA National Organisation for Victims Assistance has produced the bulletin *Working with Victims of Crime with Disabilities* (Tyiska, 1998). This bulletin contains recommendations and resources for networking and training with the Criminal Justice System to improve services provided to people with a disability who are victims of crime. Available from www.ojp.usdoij.gov/ovc/publications

KNOWLEDGE SYSTEMS

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
DEFINING AND DESCRIBING ABUSE	☑ That definitions are consistent ☑ That definitions are built into service guidelines and policies ☑ Maintaining the broad meaning of 'abuse' prevents a narrow focus on specific acts or incidents, while clear and consistent definitions improve the capacity of service systems to identify, address and respond to risks and incidents. The examples below have been adapted from various sources (see Literature Review). The categories of constraint and financial abuse have been identified as of particular importance for people with a disability. ☑ Consistent definitions across service sectors (e.g. aged care, community care and child care) may improve the capacity of service systems to share systematic approaches to abuse prevention.	☞ Analysis suggests that multi-layer descriptions of both abuse and neglect may be of greatest value within service systems, with care taken to ensure that such definitions do not prevent accurate identification of serious and potentially criminal actions. ☞ There is also value in plain English definitions of abuse and neglect for raising the awareness of abuse among the general community and people with a disability receiving support from CSDA-funded services. ☞ Example 2: Describing Abuse and Neglect ☞ Example 1:Plain English Definition of Abuse/Neglect
DATA COLLECTION AND ANALYSIS	☑ Identifying the impact of abuse and the cost of abuse to individuals and the broader community ☑ Increased data collection and analysis with regard to the incidence of various forms of abuse across different service types ☑ Consumer complaints are reviewed to improve service practices. ☑ Identify the incidence of child abuse among children with a disability.	☞ Example 40: Crime Victims With Disabilities Awareness Act (USA)
EVALUATION	☑ Training and information resources are evaluated for their effectiveness. ☑ Policies and Procedures related to abuse prevention are evaluated. ☑ Prevention strategies are evaluated. ☑ The effectiveness of child abuse prevention strategies are evaluated with regard to the outcomes for children with a disability.	

MECHANISMS	AREAS FOR IMPROVEMENT AND SUCCESS FACTORS	EXAMPLES OR POINTS OF INTEREST
RESEARCH AND DEVELOPMENT	☑ Further research is needed to develop approaches for identifying risk and appropriate family-centred intervention. ☑ Reducing financial abuse within CSDA-funded disability services has the potential to increase the financial independence of consumers and their satisfaction with support provided. ☑ Quality benchmarks are raised as overall standards and expectations increase. ☑ Tools and models for predicting abuse are developed. ☑ Service environment risk assessment is linked to continuous quality improvement. ☑ Crime prevention strategies may be appropriately applied within service settings or with populations of people supported in the community; more assistance may be required for services to implement strategies of this nature starting with sound data regarding incidence and patterns.	☞ The development of risk assessment tools for older people may provide a starting point for the development of risk assessment tools for people with a disability, see for example: Wolf R., (2000) *Risk Assessment Instruments*_Special Research Review Section: National Center on Elder Abuse Newsletter, September available from www.elderabusecenter.org/research/risk.html

PART 2: REVIEW OF LITERATURE AND CURRENT PRACTICE

INTRODUCTION

This review has been undertaken by the National Disability Administrators on behalf of Commonwealth, State and Territory Minister's responsible for disability services in Australia. It has been undertaken to inform the development of the Framework for Improving Abuse Prevention within specialist disability services. The review is structured to support to the key principles identified in the Framework.

The primary work of this project is the critical analysis of quality assurance and abuse prevention in CSDA-funded services and other comparable sectors in Australian and international jurisdictions. The analysis will focus on what can be learned from current practice and research, for application in local contexts. From this will be derived a set of key principles for an effective abuse prevention framework capable of tailoring to best fit conditions across States, Territories, populations and program types.

The review has involved a number of activities including:

- Analysis of Australian and International literature regarding abuse prevention in human services, particularly with regard to the provision of services to vulnerable adults and children.
- The compilation of a national summary of quality assurance processes and abuse prevention strategies in Australian CSDA Jurisdictions.
- Consultation with Commonwealth and State/Territory government agency representatives administering disability support services, aged care and services to people with a mental illness.

Clear parameters were required to guide the identification of literature that was to be included in this review. This is particularly important in the complex area of abuse where evidence of effectiveness can be complicated by under-reporting, lack of cohesion in the definition of abuse, diversity in awareness of the many types of abuse, as well as both community and individual sensitivities in this area. After a preliminary scope of available research the review has focused on work that has currency in the international and Australian community services sector, meaning that it remains relevant to the way in which services and practices are provided or developing.

Much of the literature on the abuse of people with a disability concentrates on abuse prevention for people with an intellectual disability, or within service

models originally developed for this population. The review has included as far as possible, literature relevant to other populations of people with a disability. However, it is important to note that people with an intellectual disability are often identified as the most vulnerable to abuse and are the largest group of people receiving support through services funded under the Commonwealth/State Funded Disability Services Agreement (CSDA) in Australia.

Overview of the Commonwealth/State Disability Agreement

The Commonwealth/State Disability Agreement (CSDA) outlines how responsibility and resources for providing services are distributed across Commonwealth and State/Territory governments. A broad range of services are provided to people with a disability via the CSDA, including the following:

- **Accommodation services** including institutions and large residential services, hostels, group homes, drop in support and in-home support.
- **Community support** including early childhood intervention, recreation and holiday programs, therapy, family/individual case management, and behaviour intervention counselling and support.
- **Community access** including continuing education, independent living training, post-school options and day programs.
- **Respite care services** including services provided at home or at an alternative centre, and host family and peer support services.
- **Employment services** including open and supported employment.
- **Advocacy services** including self advocacy groups, citizen advocacy, and family advocacy.
- **Information services** including print disability services, education or training services, and related research and development.

A snapshot of the number of consumers using CSDA related services on a typical day in 2000 is provided in Appendix 2.

Under the CSDA, government agencies in each jurisdiction have the following responsibilities:

- Assessing the need for services and planning service provision, in consultation with the community.
- Determining access to services and coordinating service delivery.
- Purchasing services.
- Ensuring quality services are provided, including monitoring and evaluation.
- Linking services and consumers to other service systems and the broader community.
- Research and policy advice regarding the issues facing people with a disability.

Each Australian jurisdiction has enacted disability services legislation. State/Territory legislation mirrors the Commonwealth Disability Services Act 1986, as required by the CSDA and governs the funding and provision of services to people with a disability.

1. UNDERSTANDING ABUSE

Over the past decade, the prevention of abuse in services for people with a disability has become a prominent issue for families, service providers, government and the community at large.

Internationally, the response to the abuse of people with disability developed later than responses to abuse in other community services sectors such as children's services, aged care and social responses to domestic violence (Conway et al, 1995). This review has therefore examined the knowledge gained across various service sectors in order to identify common principles.

Approaches that have evolved to prevent the abuse of people with a disability, children and older people are closely connected. There is considerable overlap between these populations and some similarity in the nature of services that are provided to each. Children, the aged and people with a disability are vulnerable to breach of trust by other individuals, services, or the state.

The need for greater understanding of abuse and the range of circumstances that constitute abuse is well recognised in the literature. Good definition and consistency in language have been identified in some circumstances as contributing to shared understanding (Goodrich, 1997); and improving understanding and response (NSW Legislative Review Unit, 1996; Conway et al, 1995; NSW Department of Community Services, 1996).

This chapter of the literature review examines:

1.1 THE LANGUAGE OF ABUSE.

1.2 CAUSES OF ABUSE.

1.3 MODELS OF ABUSE AND ABUSE PREVENTION.

1.4 INCIDENCE AND IMPACT OF ABUSE.

1.5 RESEARCH AND ANALYSIS.

1.1 THE LANGUAGE OF ABUSE

Broad definitions of abuse include:

"A violation of an individual's human and civil rights by any other person or persons." (UK Department of Health, 2000).

"The non-accidental injury of a person by another or the committing of acts that could result in injury, through acts of commission or omission." (Baladerian, 1991).

"The mistreatment of children or adults." (Sobsey, 1994).

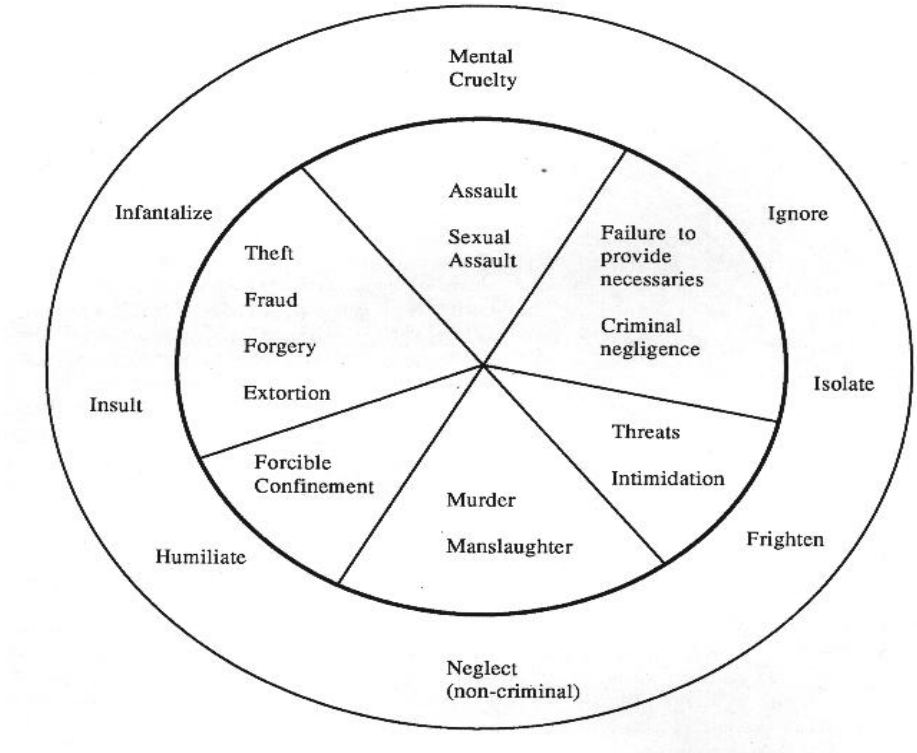
The term 'abuse' has no legal meaning as a criminal act; rather, it is the offences that constitute some forms of abuse (for example, assault, unlawful imprisonment, sexual assault, rape) that are criminal. (Sobsey, 1994).

It is important not to mask serious offences through failure to use the correct legal term when a serious crime has been committed (Conway et al, 1995; Sobsey, 1994). Terminology should not trivialise or decriminalise serious offences, for example criminal acts such as assault, rape, homicide and theft should not be described in language as 'aversive treatment' or 'inappropriate behaviour'. Using 'softer' terminology prevents appropriate response to and recognition of such actions.

This does not suggest that 'abuse' should be conceptualised as individual or isolated actions or offences. The conditions that lead to abuse are more likely to be systemic than accidental (Sobsey, 1994).

The following diagram indicates criminal and non-criminal behaviours. Charges may be laid for any of the offences in the inner circle. Offences in the outer circle may be equally as serious as those in the inner circle, but cannot often be prosecuted.

Figure 6: Criminal and non-criminal abusive behaviour



This diagram was adapted from the Advocacy Centre for the Elderly (1988) "Elder Abuse: The Hidden Crime". Toronto: Advocacy Centre for the Elderly and is reproduced as it appears in Health and Welfare Canada, 1993.

Abuse can take many forms - there is value in developing resources that assist individuals and organisations to identify actions or incidents as constituting abuse and respond appropriately. Forms that abuse can take include the following:

- **Physical Abuse***: "any non-accidental physical injury or injuries to a child by a care provider"* (Baladerian, 1991).
- **Sexual Abuse**: *"touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the [older] person is unable to understand, unwilling to consent, is threatened, or physically forced to engage in sexual behaviour"* (Levitt and O'Neill, 1997). *"Any sexual contact between an adult and a child 16 years of age and younger"* (Baladerian, 1991).
- **Emotional Abuse**: *"verbal assaults, threats of maltreatment, harassment, or intimidation so as to compel the older person to engage in conduct from which he has a right to abstain or to refrain from conduct in which the [older] person has a right to engage*" (Levitt and O'Neill, 1997*). "A pattern of verbal assaults or coercive measures towards a child that destroys his/her self-esteem"* (Baladerian, 1991). *"The emotional abuse that comes from failure to interact with a client or to acknowledge the person's presence"* (Conway et al, 1995).
- **Financial abuse**: *"the improper use of another person's assets. Although 'improper' may often mean to the 'benefit of someone other than the victim' it is not necessary for someone other than the victim to benefit, it is enough for the victim to suffer harm as a result of financial abuse"* (Dessin, 2000). *"Withholding finances is a common form of abuse"* (Conway et al, 1995).
- **Confinement**: *"restraining or isolating a person for other than medical reasons"* (Levitt and O'Neill, 1997). Burdekin (1993) and Conway (1994) publicly place **chemical restraint** in the catalogue of Australian techniques of abuse.
- **Legal Abuse**: *"describes the failure of the legal system to provide justice and access to people with a disability as forms of abuse"* (Reid 1994, cited in Conway et al, 1995).

Conway et al (1995) canvassed the notion of abuse and neglect as a continuum. The impact of neglect may be similar to that of abuse, however the term implies a pre-existing relationship between the people involved and a duty of care toward to the person who is abused. Both abuse or neglect may each involve a breach of trust but neglect also involves a breach of duty or responsibility. Neglect may be broadly defined as failure to provide the necessary care, aid or guidance to dependent adults or children by those responsible for their care (The Roeher Institute, 1995a). Or, staff omissions of care that produce harm (Conway et al, 1995). Neglect may take the following forms:

- **Physical Neglect**: *"failure to provide adequate food, shelter, clothing, protection, supervision and medical and dental care" (Baladerian, 1991).*
- **Passive Neglect**: *"a caregiver's failure to provide or wilful withholding, of the necessities of life, including but not limited to food, clothing, shelter or medical care"* (Levitt and O'Neill, 1997).
- **Wilful Deprivation**: *"wilfully denying a person who, because of age, health or disability, requires medication, medical care, shelter, food, therapeutic device or other physical assistance, and thereby exposing that person to risk of physical, mental or emotional harm, except if the elder has expressed an intent to forego such medical care" (Levitt and O'Neill, 1997).*
- **Emotional Neglect**: *"the failure to provide the nurturance or stimulation needed for the child's social, intellectual and emotional growth"* (Baladerian, 1991).
- **Crimes of omission**: *"as the failure to act with appropriate duty of care" (Tobin, 1999).*

Consistency in reporting abuse (in Australian child protection services) has been identified as a way to improve understanding of incidence and evaluation of prevention strategies (Australian Institute of Health and Welfare, 1999). This principle was also identified as a valuable approach to improving interagency collaboration with regard to populations of vulnerable adults and young people, particularly those who are dependent on community services (UK Department of Health, 2000).

Improved description and understanding of abuse can assist with abuse prevention strategies in the following ways:

- Educating the public, vulnerable people, service providers, government agencies and care providers with regard to abuse.
- Developing systems that assist the identification of abuse.
- Ensuring appropriate response to specific forms of abuse.
- Monitoring the incidence of abuse and specific forms of abuse.
- Evaluating the effectiveness of abuse prevention strategies.

The advantage of consistency in language and data collection must be balanced against the risk of narrowing the meaning of abuse by over zealous definition. Policies on recognising abuse should reflect the diversity of types of abuse that can occur singly or in combination and not exclude some forms of abuse or potential forms of abuse due to overly narrow or prescriptive definition (Conway et al, 1995). Brown and Stein (1998) identify the risk of differential awareness of abuse amongst professionals when there is emphasis on specific forms of abuse relevant to certain populations or settings.

Definitions and descriptions of the terms ‘abuse’ and ‘neglect’ are typically provided in manuals or policy guidelines provided to funded services in Australian CSDA jurisdictions. Such descriptions can vary considerably in the breadth of meaning implied and the examples that are provided. Particular types of abuse that are not well-covered in CSDA publications include financial abuse, constraint or restrictive practices, and systemic abuse such as withholding of services or denying access to supports.

Example 1 below, provides a plain English description of abuse from Northern Territory Health Service. Following this, Example 2 provides a set of descriptions of various forms of abuse and neglect. This set of descriptions was developed during this project, with consideration to the range of descriptions available and issues related to description and definition in the literature.

Example 1: Plain English Description of Abuse (NT)

> Abuse is doing or not doing something that hurts a person. Abuse can mean physically or emotionally hurting someone (for example: hitting punching, name calling or threats) or taking away a person’s freedom, rights or support (for example not giving someone food, stealing money or belongings or locking someone up).
>
> Reference: *Northern Territory Health Services, (1999) Disability Services Standards Implementation Guide.*

Example 2: Descriptions of Abuse and Neglect (Various)

DESCRIPTION	CRIMINAL ACTS
Abuse is the violation of an individual's human or civil rights, through an act or actions of commission or omission, by another person or person(s). Including, but not limited to: ■ **Physical Abuse:** any non-accidental physical injury or injuries to a child or adult. This includes inflicting pain of any sort or causing bruises, fractures, burns, electric shock, or unpleasant sensation such taste, heat, cold. ■ **Sexual Abuse:** any sexual contact between an adult and a child 16 years of age and younger; or any sexual activity with an adult who is unable to understand, has not given consent, is threatened, coerced or forced to engage in sexual behaviour. Sexual activity includes intercourse, genital manipulation, masturbation, voyeurism, sexual harassment etc. ■ **Psychological or Emotional Abuse:** verbal assaults, threats of maltreatment, harassment, humiliation or intimidation or failure to interact with a client or to acknowledge the person's presence. This may also include denying cultural or religious needs and preferences. ■ **Constraint and Restrictive Practices:** restraining or isolating an adult for reasons other than medical necessity or the absence of a less restrictive alternative to prevent self-harm. This may include the use of chemical or physical means or the denial of basic human rights or choices such as religious freedom, freedom of association, access to property or resources or freedom of movement. ■ **Financial Abuse:** the improper use of another person's assets or the use or withholding of another person's resources. ■ **Legal or Civil Abuse:** denial of access to justice or legal systems that are available to other citizens. ■ **Systemic Abuse:** Failure to recognise, provide or attempt to provide adequate or appropriate services, including services that are appropriate to the consumers age, gender, culture, needs or preferences.	■ Physical assault ■ Battery ■ Rape ■ Sexual Assault ■ Indecent Assault ■ Sexual Offences such as indecent exposure. ■ Harassment ■ Discrimination ■ Unlawful imprisonment ■ Unlawful restraint ■ Theft ■ Sexual vilification & harassment ■ Racial Discrimination
Neglect: Failure to provide the necessary care, aid or guidance to dependent adults or children by those responsible for their care. This may include, but is not limited to: • **Physical Neglect:** failure to provide adequate food, shelter, clothing, protection, supervision and medical and dental care, or to place persons at undue risk through unsafe environments or practices. • **Passive Neglect:** a caregiver's failure to provide or wilful withholding, of the necessities of life, including but not limited to food, clothing, shelter or medical care. • **Wilful Deprivation:** wilfully denying a person who, because of age, health or disability, required medication, medical care, shelter, food, therapeutic device or other physical assistance, and thereby exposing that person to risk of physical, mental or emotional harm. • **Emotional Neglect:** the failure to provide the nurturance or stimulation needed for the social, intellectual and emotional growth or well being of an adult or child.	■ Deprivation ■ Negligence

KEY FINDINGS

1. The identification and appropriate response to abuse is assisted by:
   - Consistent language used to describe abuse and neglect;
   - Descriptions of abuse that do not trivialise or decriminalise acts of abuse but rather provide a broader basis than criminal definitions for addressing systematic harm perpetrated on people with a disability; and
   - Collaboration across human service sectors.

1.2 PATTERNS OF ABUSE

Common examples of abuse against people with a disability in CSDA-funded services are consistent with those identified across a range of service sectors working with vulnerable adults (see for example Conway et al, 1995). Patterns of abuse might be described as:

- Serial abusing where the perpetrator seeks out vulnerable individuals. Sexual abuse usually falls into this pattern, as do some forms of financial abuse.
- Long-term abuse in the context of an ongoing family relationship such as domestic violence.
- Opportunistic abuse such as theft occurring because money or possessions are left around or easily taken, e.g. staff taking financial advantage of residents with regard to food and telephone calls.
- Situational abuse that arises because pressures have built up and/or because of difficult or challenging behaviour.
- Neglect of a person's needs, because those around him or her are unable to provide care or there is a lack of services or inappropriate services.
- Institutional abuse which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service.
- Unacceptable 'treatments' or programs which include punishment such as withholding of food and drink, seclusion, unnecessary or unauthorised use of control and restraint or over-medication.
- Failure of agencies to ensure staff receive appropriate guidance on anti-discriminatory practice and cultural sensitivity.
- Failure to access key service such as health care, dentistry, prosthesis.
- Misappropriation of the person's money by others; fraud or intimidation.

(Adapted from UK Department of Health, No Secrets, 2000)

Brown and Stein (1998) suggest that the identification of different patterns of abuse across different groups of vulnerable adults may rest as much on worker expectations as the actual occurrence of abuse. For example, professionals may be more likely to recognise the financial abuse of older persons than the same form of abuse against people with a disability.

1.3 CHARACTERISTICS OF PERPETRATORS

People with a disability are more likely to experience abuse by someone they know, either a family member, paid support worker or another person with a disability especially those clustered with their victims in service settings (Sobsey, 1994). It is important to remember that the majority of people in these categories do not abuse people with a disability.

Conway et al (1995) found that within residential services for people with an intellectual disability, across all types of abuse reported, 51% of abusers were classified as residential service staff followed by 21% classified as fellow residents. Similar findings have been reported in other work (see for examples: McCarthy and Thompson 1996; Sobsey and Doe, 1991; Brown and Stein, 1998; Audit Office of NSW and Ageing and Disability Department, 2000).

With regard to sexual abuse, Muccigrosso (1991) suggests that 99% of reported incidents of sexual abuse of people with developmental disabilities is by persons known to the victim, not strangers. Conway et al (1995) found that strangers were only identified as abusers in 5% of sexual abuse cases reported by families and 17% of staff respondents. This is not dissimilar to the area of child abuse, where people who abuse are typically known to the child (National Child Protection Council, 1996).

Within services for people with a disability, there is considerable evidence that those who perpetrate sexual abuse of children and adults, generally seek out or exploit opportunities for unsupervised contact with potential victims (Community Services Commission of NSW, 1996). Offenders are often skilled at gaining the trust of potential victims and those who might otherwise protect them.

Most sexual abusers are male and their victims, female. Segregated service models increase dependency on caregivers for support and advocacy, making the individual more vulnerable to sexual assault and emotional abuse (The Roeher Institute 1997; Audit Office of NSW and Community Services Commission of NSW 1997; Sobsey 1994; Chenoweth, 1995; Community Services Commission of NSW, 1996; Conway et al, 1996).

In contrast, physical or emotional abuse or neglect is more likely to be unplanned and influenced by features of the care environment such as ratios of caregivers, lack of resources, inadequate training and supervision (Glendenning, 1999; Community Services Commission of NSW and Intellectual Disability Rights Service, 2001).

Saveman et al (1999) examined characteristics of perpetrators of abuse against older people in a residential setting in Sweden. This study found that personal characteristics of the abusers included that they were aggressive and easily lost their temper, exhausted and burnt-out and/or dominant and egotistic. Mental health problems and lack of knowledge were mentioned as other characteristics. More than one type of abuse was reported in the same situation. Physical abuse was most commonly reported followed by psychological abuse and 80% of the reported abuse occurred in caring situations e.g. where assistance was given with daily living or personal hygiene.

The Performance Audit of Group Homes in NSW (Audit Office of NSW and Ageing and Disability Department, 2000) identified incompatibility among residents as a common cause of injury, aggression, hostility, threats, intimidation and fear within services. Less obvious manifestations were individual's needs not being met, living skills being lost and more demanding residents monopolising the staff's time. While these issues were only examined in 13 group homes, in more than half of these, assault behaviour issues were identified.

Abuse such as theft, constraint and unlawfully restrictive practices are more likely to be committed by caregivers when people with a disability are dependent on support for assistance with financial management or behaviour management.

KEY FINDINGS

2. Vulnerability to various forms of abuse may be interconnected and prevention strategies may serve to reduce the likelihood of various forms of abuse.

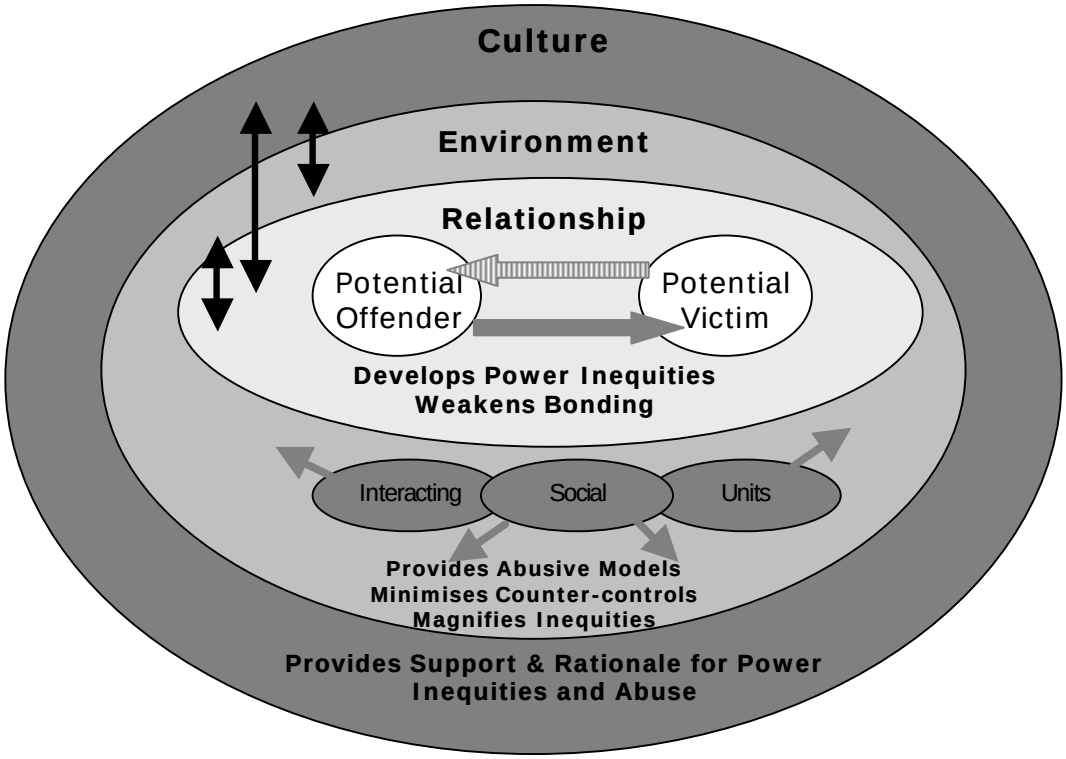
1.4 MODELLING ABUSE AND PREVENTION

Factors that contribute to abuse include those beyond the immediate relationship between the victim and the offender. Bronfenbrenner (cited in Sobsey, 1994) described an ecological model of child abuse that includes cultural ideology, social institutions, service systems interacting with families and the dynamics within the family unit as all-important contexts to the interactions between parents and children.

Sobsey (1994) adopts the fundamental principles of Bronfenbrenner's model and adds other models of abuse (counter-control and social learning) to develop an integrated ecological model of abuse relevant to people with an intellectual disability that captures the many reasons why people with a disability experience increased risk of abuse. He argues that much of the vulnerability attributed to and experienced by people with a disability appears to be socially constructed. Thus only a model grounded in social and cultural ecology can be expected to control that vulnerability. Components of Sobsey's model include:

- **Relationships** between potential offenders and potential victims which can be influenced by characteristics of the victim such as dependency, learned compliance, and impaired communication or physical defences; and characteristics of the potential offender such as a need for control, exposure to abusive behaviour, devaluing attitudes and low attachment to the victim.
- **Environments** that can emphasise control, isolate people from society, attract abusers, conceal abusive behaviour, dehumanise people, and discourage attachment**.**
- **Culture** that devalues people with a disability, teaches compliance, denies problems, discourages attachment, objectifies potential victims etc. This model places emphasis on the relationship between potential offenders and potential victims within the context of the direct environment and broader cultural context.

Figure 7: Integrated Ecological Model of Abuse (Reproduced from Sobsey, 1994)



The Figure above appears in Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance? By Dick Sobsey, 1994 Paul Brookes Baltimore, (page 160) with the following caption: The integrated model of abuse. Physical and psychological aspects of the interacting individuals are considered within the context f environmental and cultural factors.

The traditional approach to developing and describing prevention strategies is the 'public health' model, which identifies:

- **Primary prevention** that targets the community as a whole and generally consists of mass media campaigns or protective behaviour training for children.
- **Secondary prevention** that targets specific 'at risk' sections of the community, primarily through providing family support.
- **Tertiary prevention** initiatives that typically aim to prevent recurrence of abuse and to support victims and offenders.

Other approaches applied to the prevention of abuse of vulnerable populations have been identified from other service sectors. These include:

- **Health Promotion** where the focus is on encouraging the development of healthy communities and positive relationships that are less likely to lead to problems, including negative attitudes, risk factors and violence. For example: the Australian National Mental Health Strategy focuses on the promotion of mental health rather than the prevention of mental illness.
- **Systems Approach** which examines the impact of service systems on the lives of consumers and seeks to improve positive outcomes and minimise negative impact. This approach has been applied to child protection services (Cashmore et al, 1994).

- **Crime Prevention** where the focus is on examining specific patterns of crime and developing intervention strategies to reduce it. This can be applied within communities, within service settings or within individual lives through risk assessment. The application of the crime prevention model to residential services for people with a disability has been examined by the Community Services Commission of NSW and Intellectual Disability Rights Service (2001).

Each of these approaches offers substantial value in improving quality and effective abuse prevention within services for people with a disability.

There is considerable overlap and interaction between primary, secondary and tertiary prevention strategies. Particularly within service systems such as the CSDA-funded disability service sector, in which a particular strategy may serve the dual purpose of decreasing the risk of abuse occurring and improving appropriate identification and response to abuse. It is also important to consider that people with a disability are both potential victims of abuse and potential perpetrators of abuse within service systems.

KEY FINDINGS

3. The prevention of violence against people with disabilities is treated in various ways in the literature. Recommendations pertaining to prevention can be characterised as involving:
    - Systematic changes to eliminate the conditions that make it likely that people with disabilities will be subject to abuse.
    - Specific preventative measures within a variety of settings to make it less likely that people will be harmed or make them less vulnerable to abuse.
    - Measures to ensure effective response to abuse when it happens.

1.5 INCIDENCE AND IMPACT

"Children and adults with disability experience increased risk for physical, sexual and other forms of abuse. They are not only more likely to be abused but when they are abused, the abuse is more likely to be chronic and severe." (Sobsey, 1994).

Research into the abuse of people with a disability has highlighted the difficulties in gaining accurate data on the extent of abuse of people with a disability (Sobsey, 1994; Chenoweth, 1995; Department of Prime Minister and Cabinet, 1993 and Conway et al 1995). The problems are attributed to inconsistent definitions and approaches to methodology and sampling in different studies, in addition to under-reporting.

Research, reviews and investigations that identify substantial and systemic abuse toward people with a disability suggest that it is frequently neither recognised nor reported (Sobsey, 1994; Chenoweth, 1995; Conway et al, 1995; Community Services Commission of NSW and Intellectual Disability Rights Service, 2001). Therefore incidence is likely to be underestimated.

Offences against people with a disability are frequently not reported to authorities due to a reluctance to involve police or pursue legal remedy when either the victim or the offender has an intellectual disability (Sobsey, 1994; Community Services Commission of NSW and Intellectual Disability Rights Service, 2001). Australian statistics collected on victims of crime typically do not identify victims who have a disability (Byrnes 1996; Community Services Commission of NSW, 1996). Additional factors contributing to under-reporting are presented in later sections of this report.

Overseas, specific legislation has been introduced in some countries to collect data on victims of crime who have a disability in order to measure the magnitude of specific problems, and to develop strategies to address the safety and justice needs of this population. For example the USA National Crime Victims with Disabilities Act, 1998 requires the identification of victims who have a disability in crime statistics.

Despite the difficulties with measuring incidence, international and Australian research has found that people with a disability are more likely to experience specific forms of abuse, when compared to the general population (for a detailed review of literature and research on this topic, refer to Sobsey, 1994). The two most common forms of abuse examined in research are sexual and physical assault.

Incidence of Sexual Abuse or Assault

- Sobsey and Varnhagen (1989) suggest that most people with disabilities will experience some form of sexual assault or abuse. Sobsey (1994) estimates up to 80% of people with a disability are sexually abused.
- Muccigrosso (1991) suggests that the incidence of sexual assault against people with an intellectual disability is at least four times higher than in the non-disabled population.
- Incidence of sexual abuse (regardless of age) among people with developmental disabilities was estimated in 1985 by the California State Department of Developmental Services to be 70% (Baladerian, 1991).

Incidence of Physical Assault

- Research undertaken in South Australia in 1990 found that people with an intellectual disability were twice as likely as people without the disability to be victims of a personal crime (eg assault) and one and a half times more likely to be victims of a property offence (Wilson, 1990 cited in NSW Law Reform Commission, 1996).
- In 1998-99 the NSW Community Services Commission of NSW reported that the highest number of complaints received with regard to the Disability Services sector, were related to assault. Assault issues represented 16% of all complaints; 95% of these involved resident-to-resident abuse[1] (Audit Office of NSW and Ageing and Disability Department, 2000).

[1] Caution might be applied to the interpretation of the high reported incidence of resident-to-resident assault as there may be a reporting bias. People with a disability, their advocates and caregivers may be more likely to recognise and take action regarding abuse perpetrated by another person with a disability in comparison to abuse perpetrated by others, such as family members or paid caregivers.

Types of abuse that have not been well identified in either research or government investigation or reports tend to be those that are not as clearly defined as sexual or physical assault. An example is the lack of published material regarding the financial abuse of people with a disability, through mismanagement of funds, restricted access to resources and inequitable wage rates in employment services. Financial abuse has been examined in more detail in literature related to the abuse of older people.

The management of challenging behaviour is an issue that warrants particular attention as there is a history of the use of excessively harsh or inappropriate behaviour management strategies and practices, some of which are now unlawful. Challenging behaviour can also involve the abuse of other people with a disability.

Conway et al (1995) found that 27% of family respondents and 24% of staff respondents reported having witnessed excessively harsh or inappropriate behaviour management. He reported overuse of medication as a consistent theme.

Residential Services

The residential care setting has been the focus of much research and prevention activity in the abuse of people with a disability in Australia (Tichon, 1998). Residential services can increase an individual's risk of abuse by creating a culture that is tolerant toward violence and crime, an environment that provides opportunity for abuse through segregation and inadequate protection, and relationships in which there is an imbalance of power, lack of attachment or poor communication (Sobsey, 1994).

Within residential and facility-based respite services there is evidence of high incidence of resident-to-resident assault. A review of large residential facilities in NSW found that resident-to-resident assault accounted for 44% of all known injuries to residents, many of which were of a serious nature (Audit Office of NSW and Community Services Commission of NSW, 1997).

Wilson (1990) identifies that the risks of crime victimisation differs across residential settings, the safest being the family home, through to the greatest risk in shared accommodation, including community residential units and residential settings such as boarding houses and hostels. Various reviews and reports have identified high levels of abuse within large congregate care facilities (Sobsey, 1994 and reports from the Community Services Commission of NSW).

Australian work indicates that where abuse and assault occur within service settings, there is a considerable risk that it will involve sustained and multiple episodes of violence and crime (Audit Office of NSW and Community Services Commission of NSW, 1997).

A high incidence of abuse by caregivers in residential service settings has been found in other service sectors including care for older people. Saveman, et al (1999) quotes 40% of American residential aged care workers admitted being psychologically abusive towards residents and 10% admitted to physical abuse of

residents. Saveman's limited quantitative survey of Swedish residential care indicated that 11% of staff knew of cases of abuse against older people that had occurred in the year preceding the survey. Dessin (2000) notes that one in four elderly Americans will suffer some form of abuse at some time.

Community Settings

Abuse is not restricted to residential service settings. It also occurs within the general population and within the context of families or community-based living arrangements. Those authors that have examined abuse in broader settings include Sobsey and Doe (1991) based on people attending sexual assault clinics regardless of their living arrangements; and Brown and Stein (1998) based on cases of sexual abuse reported through statutory agencies.

The USA National Study of Women with Physical Disabilities (Young et al,1997) found that women with physical disabilities living in the community experienced the same incidence of abuse that all women face (reported to be 60% in this study), plus additional risks specifically related to their disability. However, women with disabilities tended to experience abuse for longer periods of time, reflecting the reduced number of escape options open to them due to more severe economic dependence, the need for assistance with personal care, environmental barriers, and social isolation.

The authors (Young et al, 1997) noted that it is difficult to separate the effect of disability from the effects of poverty, low self-esteem, and family background in identifying the precursors to violence against this population

The Impact of Abuse

Incidence is a blunt instrument when attempting to establish the extent of abuse in the lives of people with a disability. Data regarding the number of reported incidents is not easily obtained and tells us little about the impact of abuse on individuals, or the effect that multiple forms of abuse over sustained periods of time has on a population.

Relatively little research has been conducted that focuses explicitly on the effects of violence and abuse on people with disabilities. Most of the literature which does exist looks at the effects of sexual abuse (The Roeher Institute, 1994). Some of these effects include the diagnosis of mental illness; social withdrawal; problems with identity formation, self-protection, intimate relationships and self-esteem; overly compliant behaviour; alienation and dissociation; isolation and problems with trust; anger and guilt; and revictimisation (by repeated assault or by people not believing or questioning the person's credibility).

Saveman et al (1999) found that, following abuse, elderly victims in residential care settings were reported to experience increased fearfulness, aggression and withdrawal.

The incidence of abuse in Australian services for people with a disability is comparable to that found in international research (Community Services Commission of NSW and Intellectual Disability Rights Service, 2001). In

particular, abuse within residential services has been identified in a number of studies.

Significant development in abuse prevention within Australian CSDA jurisdictions has typically been reactive, following major service reviews or investigations that have identified systemic and extreme abuse. There does not appear to be a consistent approach to identifying, examining and learning from patterns of abuse and violence across the broad range of service types and experiences of people with a disability.

KEY FINDINGS

4. The capacity of services to reduce abuse and violence in the lives of people with a disability relies on ongoing development in the areas of identification, prevention strategies and appropriate responses.
5. Increased data collection and analysis with regard to the incidence of various forms of abuse across different service types may assist the development and evaluation of prevention strategies

1.6 RESEARCH AND ANALYSIS

Substantial work has been undertaken to examine abuse within specific settings such as residential facilities. There is also a large body of work that examines family-based violence against children, women and older people. While much can be learnt from this work, the population of people with a disability is highly diverse. People with a disability have a broad range of support and service needs that may create vulnerability to abuse across a wide range of settings including home, work and community. Preventing the abuse of this population is therefore a more difficult systemic issue than abuse prevention within defined sectors or service types such as residential aged care facilities, or family-based child protection. More specific research into vulnerability factors and prevention strategies across the diversity of this population and their experiences is needed.

With regard to research looking specifically at the lives of people with a disability, increased risk to abuse is well established and approaches to modelling abuse are evolving (Sobsey, 1994). More research is required to examine abuse within specific service models for people with a disability such as employment services, respite care services, and community based accommodation support services, as research has historically focused on residential facilities and group homes.

Tichon (1998) has identified the need for research specific to the area of families caring for adults with an intellectual disability. After a review of Australian and international approaches to abuse in the family context, she argues that initial procedures can be guided by other areas of family violence, including the abuse of older people. The development of more effective prevention approaches for people with a disability needs to be better informed by more knowledge regarding the indicators of abuse incidence and nature of abuse, the relationship between family functioning and abuse and the development and testing of intervention models.

Some areas for further research include the following (Sobsey, 1994; The Roeher Institute, 1994):

- Clarify the conditions that increase risk and the conditions that increase safety, in order to guide the development of prevention programs.
- Research to validate prevention and intervention programs.
- The development of strategies to assist agencies to work collaboratively.
- The identification and response to systemic issues in abuse and violence against people with a disability.

The application of crime prevention approaches to service settings has considerable potential. For example, a recent discussion paper prepared by the Community Services Commission of NSW and Intellectual Disability Rights Service (2001) recommends the application of a crime prevention framework in residential services in order to:

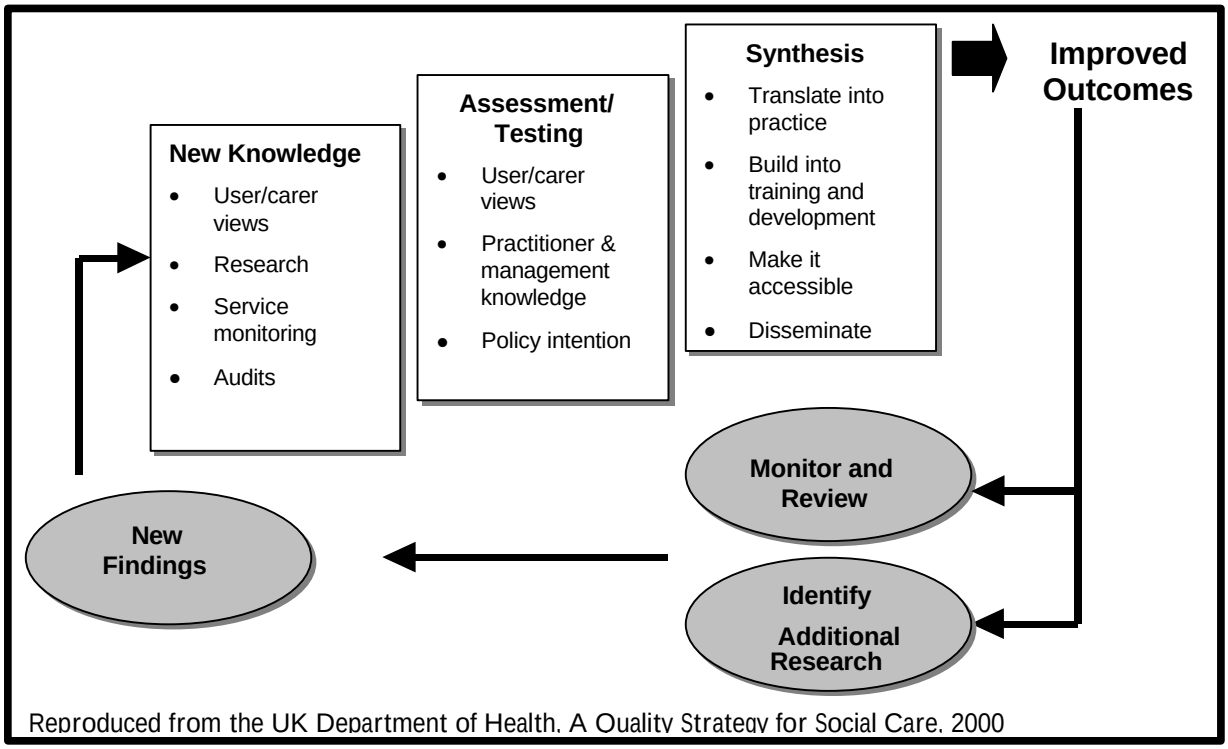
- Provide a context within which acts of violence and abuse may be recognised as a crime against people with a disability.
- Ensure a focus on how to reduce the risk of criminal events occurring, rather than responding after the event.
- Enable disability services to draw on examples of effective crime prevention initiatives in other settings.

This model might be applied to other settings and service types. Trial and evaluation of these approaches is likely to contribute significantly to knowledge and understanding of abuse within service settings.

Strategies to prevent abuse within Australian CSDA jurisdictions appear to have had little review or evaluation. The need for ongoing research is part of the picture. There is also a need to build research and evaluation into systems development to ensure the effective application of knowledge. The diagram below provides a systems approach to the development of knowledge and guidelines in social services.

Further research into the impact of culture is needed to better understand the dual interaction of disability and culture with regard to the incidence of abuse. For example, the abuse of indigenous people who have a disability may differ in incidence and type to that of non-indigenous people who have a disability. There is a lack of published research that examines the experiences of indigenous Australians who have a disability or the experiences of people with a disability from diverse cultural and linguistic backgrounds.

Figure 8: Developing Knowledge and Guidelines



Reproduced from the UK Department of Health, A Quality Strategy for Social Care, 2000

KEY FINDINGS

6. Ongoing research and analysis into the abuse of people with a disability is particularly needed in the following areas:

   - To identify the conditions that increase risk and the conditions that increase safety, across the diversity of service and community settings in which abuse occurs;
   - To investigate the interaction of disability and culture with regard to the incidence of abuse, including the experiences of indigenous people with a disability and those from diverse cultural backgrounds;
   - To ensure that increased knowledge results in improved practice, through continuous improvement mechanisms; and
   - To evaluate the effectiveness of prevention strategies, including the application of emerging models in crime prevention and community harm minimisation within the disability services sector.

2. PRIMARY PREVENTION

"The prevention of the abuse and neglect of [older] vulnerable adults is a community challenge which will not be resolved quickly by one person or one approach. It will require a community effort to create an environment which reaffirms the right of older adults to self-determination, respect and dignity." (Health and Welfare Canada, 1993a).

The primary prevention of abuse has as its target the broader community or cultural context in which abuse occurs. The literature regarding the abuse of people with a disability recognises that although abuse often occurs within service settings, services operate within a broader cultural context which impacts on the service environment and the vulnerability to abuse of people with a disability.

Cultural beliefs or attitudes that contribute to the abuse of people with a disability include:

- "Blame the Victim"

  People with a disability are sometimes seen as having characteristics that attract abuse and therefore they are seen as the cause of the abuse (National Child Protection Council, 1996).

- Devaluing people with a disability

  People with a disability are seen as not having the same rights as other people (Cootes et al 1995) and are stigmatised and depersonalised (Community Services Commission of NSW, 1996).

Addressing factors in the cultural context, which increase or decrease the likelihood of abuse occurring are most likely to have a long-term impact on abuse prevention. Primary prevention components of an effective framework have been identified as:

2.1 INCLUSIVE COMMUNITIES.

2.2 ADVOCACY.

2.3 BUILDING INDIVIDUAL RESILIENCE.

2.4 FAMILY SUPPORTS AND INTERVENTION.

2.1 INCLUSIVE COMMUNITIES

Several hypotheses have been put forward to explain why responses to the abuse of people with a disability have lagged behind those of other groups. Explanations typically centre on the devalued status that people with a disability have had in the community and the isolation of people in institutional settings (Conway et al, 1995; Sobsey 1994; Ammerman & Baladerian 1993 cited in Orelove et al 2000).

This has resulted in community ignorance of not only individual instances of abuse, but also the abusive nature of institutional settings per se (Sobsey, 1994).

Services provided to people with a disability can act to increase the risk of abuse by isolating people and creating abusive environments (The Roeher Institute, 1995a; Conway et al, 1995; Sobsey, 1994; Kennedy and Co, 1997). The most commonly cited factors linked to heightened risk of abuse are social and physical segregation, and isolation from natural support networks and the community.

Sobsey (1994) explains the heightened risk that people living in institutional or segregated settings experience due to clustering, reduced opportunities to learn self protective and social behaviours and limited positive relationships with other people and advocates. The same features characterise many large congregate employment services and day programs.

Myths and stereotypes about disability also contribute to a lack of understanding within the community with regard to abuse. For example, the myth that people with disabilities are not sexual people has led to misconceptions that they are not at risk of sexual abuse (Muccigrosso, 1991).

Broad approaches to the prevention of the abuse of people with a disability have been reviewed by a number of authors. The importance of the following strategies have been identified:

- Deinstitutionalisation of services and the integration of people with disabilities into the community (Sobsey, 1994; The Roeher Institute, 1995a).
- Changing attitudes regarding disability, through public education, increasing valued status and providing opportunities for social participation (Sobsey, 1994; The Roeher Institute, 1995a; National Child Protection Council, 1996; Carney, 2000).
- Addressing financial dependence on others through access to paid employment; adequate levels of income support (The Roeher Institute, 1994). Ensuring that support services are affordable (Sobsey, 1994).

Changing attitudes toward people with a disability is a necessary step toward reducing their risk of violence and abuse (Sobsey, 1994). This statement has been echoed by the National Child Protection Council (1996) with regard to the prevention of abuse of children with a disability.

Community education campaigns are a significant feature of abuse prevention frameworks in mental health, the prevention of elder abuse and the prevention of child abuse.

The Department of Health and Welfare in Canada (1993a) suggests that increased awareness of the problem of abuse encourages abused or neglected older adults to seek assistance; in addition to helping members of the broader community to identify abuse and neglect and intervene appropriately. Public education strategies can also be useful in highlighting existing resources that are available to abused or neglected older adults (Nerenberg & Garbuio, 1987 cited in Health and Welfare Canada, 1993a).

Community education is one component of *Community Awareness and Response to the Abuse and Neglect of Older Adults*, a Canadian strategy that identifies that the goals of public education in abuse prevention may include:

- Educating the public about the serious nature and effects of abuse and neglect of older adults.
- Making people aware of the diversity of factors which precipitate abuse and neglect and helping people learn to recognise the indicators.
- Providing older adults with information about their rights.
- Publicising materials in diverse languages based on the linguistic composition of the community.
- Educating people about the normal aging process in order to change stereotyped attitudes.
- Helping students in school to develop positive images of older adults, for example: inter-generational visits.

Lessons in community education can be learnt from the Australian National Mental Health Strategy Evaluation (1997). This strategy included the Community Awareness Program, an ambitious community education campaign.

In the evaluation of the Strategy, strong support was expressed for the Community Awareness Program and its impact on raising awareness of mental health issues. Its major achievements were the validating effect it had on consumers, as well as the written materials, which were used and referred to by many community groups. However, the Program was not considered successful in changing community attitudes or behaviour towards people with mental illness. For mental health service providers, promotion work is a low priority. Defining what is expected of service providers and the relative roles of primary health care in promoting mental health issues is needed. On a positive level better outcomes were reported when services targeted action at sections of the local community which, as a result of their attitudes, created difficulties for mentally ill people. Special campaigns of this sort would benefit from national support in the form of education materials, advice or funds (Extract from the National Mental Health Strategy Evaluation, 1997).

Example 3: Strategies to Raise Awareness - National Child Protection Council (Aust.)

The National Prevention Strategy for the prevention of child abuse for children with a disability included a number of strategies to raise awareness and change community attitudes toward child abuse, including:

- The establishment of state-wide networks of local groups focused on preventing child abuse in their community.
- The development of information packages to assist professionals and community organisations to raise community awareness including prevalence, causal factors, the consequences of abuse, prevention measures and where to get help.
- A mass media campaign combining both positive and negative messages reinforcing the value of children and the unacceptable nature of abuse.

Reference: National Child Protection Council (1996) *Proposed Plan of Action for the Prevention of Abuse and Neglect of Children with Disabilities*,

Example 4: Community Awareness Program - National Mental Health Strategy (Aust.)

The Community Awareness Program an ambitious communality education campaign, involving mass media advertising, and extensive distribution of materials. In the evaluation of the Strategy strong support was expressed for the Community Awareness Program and its impact on raising awareness of mental health issues. Its major achievements were the validating effect it had on consumers as well as the written materials that were used and referred to by many community groups. However the Program was not considered successful in changing community attitudes or behaviour towards people with mental illness. For mental health service provider's promotion work is a low priority defining what is expected of service providers and the relative roles of primary health care in promoting mental health issues is needed. On a positive level better outcomes were reported when services targeted action at sections of the local community which as a result of their attitudes created difficulties for mentally ill people. Special campaigns of this sort would benefit from national support in the form of education materials advice or funds.

Reference: National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy Final Report.*

Reducing Isolation

"The current trend toward community services has reduced the population of institutions, but it has also resulted in a greater concentration of people with the most severe needs living in institutional settings. Until and unless good alternatives can be provided for every individual in the community, institutions will continue to exist. As long as they exist, providing the best possible quality of life to the people who inhabit them is crucial." [Sobsey, 1994]

Supporting the inclusion of people with a disability in the community, reducing isolation or segregation, and promoting independence are key objects of Disability Services legislation and Disability Discrimination legislation across Australia.

Australian CSDA programs in all Australian States, (excluding the Territories, ACT and NT, where it is not applicable), have a planned approach to replacing congregate residential service facilities with community-based integrated service models. The Commonwealth approach to determining employment service models is to enhance individual choice and portability of funding to enable people with a disability to choose from among alternative employment support options.

Despite the commitment to devolution, it is likely to be some time before segregated services are no longer a significant part of the way in which services to people with a disability are provided.

Strategies to reduce social isolation within these service models include the Community Visitors Programs currently operating in New South Wales and Victoria. The Commonwealth Department of Health and Aged Care also operates a Community Visitors Program within residential aged care facilities. These programs appoint independent community visitors to build and maintain relationships with people in services who are otherwise socially isolated. Such programs have been evaluated in performance audits and found to be effective in contributing to the ongoing improvement of service quality to vulnerable individuals.

In some States/Territories there are also programs operated by advocacy support organisations and by government and non-government service providers to facilitate relationships between people living in residential services and members of the community. The relative effectiveness of these approaches has not been evaluated.

Increasing friendships and the use of community facilities for those using large accommodation services are also strategies identified by consumers for improving service quality, identified in the National Satisfaction Survey of Clients of Disability Services (Productivity Commission, 2000).

Example 5: The Community Visitors Scheme (NSW)

In New South Wales there are 34 appointed Community Visitors who visit residential services for children, children with a disability, and adults with a disability throughout NSW. The Visitors advocate for and protect the interests of children, young people and people with disabilities living in full-time residential care. They provide advice about how to improve residents' quality of care to the Minister and the Commissioner for Community Services. Residents who are at greatest risk receive priority.

The Visitors are coordinated by the Community Services Commission of NSW. However, they are independent from the Commission and responsible directly to the Minister for Community Services. Community Visitors are appointed by the Minister for Community Services under the Community Services (Complaints, Review and Monitoring) Act 1998. The NSW Audit of Group Homes supported the role of the community visitors while recommending strategies to further strengthen the program:

- A review of the capacity of the Community Visitors Scheme to maintain adequate and effective contact with residents is required, given the increasing number of visitable services and clients.
- Enhanced procedures are required for the Community Visitors to bring issues and complaints to the attention of service providers and for the Community Services Commission to provide feedback to the Community Visitors on matters at hand.

Reference: Audit Office of NSW and Ageing and Disability Department (2000) *Performance Audit of Group Homes for People with a Disability.*

Enhancing Valued Status and Raising Awareness

Foundation work in raising the valued status of devalued people was undertaken by Wolfensberger (Osburn, 1998; see also Wolfensberger, 1983) who developed the theory of Social Role Valorisation. This theory suggests that to raise valued status, social services must provide opportunities for people with a disability to hold valued social roles including employment, citizenship, family and social networks and to promote positive images and evidence of competency.

The CSDA service system has a number of mechanisms to promote the valued status of people with a disability to the broader community and to address negative attitudes. These include Disability Service Standards related to 'Integration' and 'Valued Status' as well as national initiatives such as the Commonwealth Disability Strategy.

Despite work undertaken to promote the integration of people with a disability in the community, there continues to be a high tolerance toward segregation, mistreatment and abuse of people with a disability. The abuse of people with a disability continues to be under-reported and under-recognised (see later section of this review).

A more significant focus on the rights of people with a disability and the elimination of abuse may be required to create an ethos of community responsibility:

"All of us are unconscious of much of the harm that we do – we are all perpetrators of abuse by our support of many service practices or our silence. By becoming conscious of what we are doing, we take on a moral responsibility to minimise further damage." (Conway et al , 1995).

Broad approaches to promoting attitude and behaviour change across the sectors of health and welfare, include:

- *Health Promotion* strategies that include public media campaigns to raise awareness (eg National Mental Health Strategy; Anti Smoking Campaigns).
- *Harm Minimisation* education to identify how and when risk and harm occur, how to recognise it and what to do to avoid it (eg Road Safety, Child Protection, Safety at Work).
- *Identifying community leaders* and recognising individual achievement (eg Australian Young Achiever Awards).
- *Education within schools* and tertiary institutions, including inclusive education practices.

Increasing Economic Participation

People with a disability are more vulnerable to poverty and the causes of this are complex and endemic. Strategies to address poverty within the population of people with a disability in Australia include providing specialist disability employment services, including open labour market and business services; income assistance and welfare reform (occurring outside of the CSDA).

The failure of some employment services to provide or ensure that people with a disability earn an industry-standard minimum wage or appropriate level of remuneration for work undertaken may be viewed as a form of financial abuse that requires further reform and consideration.

In addition to inadequate wages, employment services that provide poor working conditions and low status or meaningless work can contribute to the devalued status of people with a disability. Quality assurance reforms introduced by the Commonwealth in employment services will aim to address this and raise performance standards through continuous quality improvement and stronger sanctions.

There has been limited attention to financial abuse across CSDA service types. In particular, improving consumers' access to personal funds has been identified by consumers as a priority area of improvement in service delivery (Productivity

Commission, 2000). Specific strategies might be developed to address this issue. Overly restrictive service practices may be resulting from a combination of factors such as lack of skills training in money handling for people with a disability, inadequate skills within services for providing assistance with financial management, and poor practice in managing resident's funds.

KEY FINDINGS

7. The devolution of residential settings and the introduction of independent community-visiting programs are primary approaches to reducing social isolation within residential support services.
8. Primary prevention includes increasing the valued status of people with a disability and reducing community tolerance for abuse and neglect. Strategies include
9. Enhancing individual valued status through services, programs and individual supports.
10. Changing community attitudes through public education campaigns, harm minimisation programs, community leadership initiatives and school-based education.
11. Activities to change community attitudes toward disability and prevent abuse may be best targeted at a local level through service providers and peak groups representing people with a disability. These activities are unlikely to be a priority for service providers unless adequately resourced and supported at a National or State/Territory level through funding, providing materials and advice.
12. An examination of financial abuse within the CSDA sector in conjunction with strategies to address poverty, has potential benefit in addressing the financial dependence and lack of resources experienced by some people with a disability.

2.2 ADVOCACY

"Where a resident does not have an advocate from within an appropriate personal network, it is the responsibility of the service provider to identify the need for assistance and to actively seek the involvement of independent advocacy on behalf of the resident." (Audit Office of NSW and Ageing and Disability Department, 2000)

Disability services often support people who have been systematically marginalised, prevented from knowing and exercising their rights, making informed choices and influencing the way in which services are provided to them.

In particular, people with a disability who live within residential services may be particularly vulnerable to being disenfranchised and require an independent advocate, relative or guardian who can represent their interests to ensure that their legal and human rights are respected (Audit Office of NSW and Ageing and Disability Department, 2000; Conway et al, 1995).

Collective advocacy for people with a disability can help to address systematic and social inequity. Furthermore, collective advocacy must be independent of funding and service delivery agencies in order to have appropriate influence over the broader socio-political environment in which policy is formed and services operate (Conway et al, 1995; Carney, 2000).

Advocacy also has a role in assisting people with a disability who come into contact with the criminal justice system either as victims or offenders of abuse (The Roeher Institute, 1994). (See also Criminal Justice Issues in Section 6 later in this review).

In Australia, Commonwealth and State/Territory governments share responsibility for funding advocacy services and programs. Non-government organisations also provide collective advocacy for populations of people with a disability. The capacity for these organisations to provide advice to government, services and individuals is an important mechanism for the prevention of abuse and unfair treatment. A recent review of the Australian Disability Advocacy Program resulted in recommendations for improving the program, including:

- Making sure that people with disabilities are not abused or treated unfairly be an objective of the Program.
- The Program should have two kinds of advocacy services: those for helping individual people with disabilities and those that focus on issues that are important to many people with disabilities; and
- That links between these types of advocacy be achieved through program structure that includes: local/regional individual advocacy services; a small number of state-based services dealing with broader issues; national peak disability bodies; and self-help advocacy services.
- Advocacy services should try harder to meet the needs of people with disabilities who are Aboriginal or Torres Strait Islander, who have different cultures and languages, and who are from small communities in the country.
- There should be a national group to represent issues important to families of people with disabilities.

Examples of effective structured approaches to social advocacy have included the Victorian Disability Services Review Panel and the NSW Community Services Commission (Carney, 2000). Both agencies were established independently of funding bodies with the power to respond to complaints or concerns; to investigate and review services and systems; and to represent the interests of people dependent upon services. It has been argued that this approach to advocacy has the most potential to affect overall outcomes (Carney, 2000).

Access to advocacy support is partly determined by the availability of appropriate services and partly by the ease of access to services (which may depend on the performance of service providers in facilitating such access).

KEY FINDINGS

13. A range of advocacy services contribute to abuse prevention: those that assist individual people with disabilities and those that focus on issues that are important to many people with disabilities.
14. Service providers have a critical role in facilitating access to advocates and advocacy services. This role can be enhanced by being built into individual support planning, risk assessment and service performance monitoring.

2.3 BUILDING INDIVIDUAL RESILIENCE

Individual characteristics can increase vulnerability to abuse or enhance resilience to abuse. Characteristics that increase vulnerability may be related to disability or may result from limited life experiences or the inadequate provision of supports.

As part of a broad approach to abuse prevention, addressing individual resilience is an important component and upholds the rights of people with a disability to information, skills development and appropriate supports. There is a need for caution in this approach as it is important not to 'blame the victim' or to attribute abuse to individual or isolated causes.

"Training (people with disabilities) can and does help to prevent abuse, but it is important to recognise that many abused people with disabilities, as with other victims of abuse, face extreme power inequities that no amount of individual training can overcome." (Sobsey 1994).

The impact of systemic causes such as service environments and power inequity can counter individual resilience (Sobsey and Doe, 1991; Roeher Institute 1995b; Mitchell and Bruchele-Ash 2000). Directing resources to address individual factors can be ineffective if the overall approach to abuse prevention fails to identify and address systemic and cultural causes (Department of Prime Minister and Cabinet, 1993).

The table below provides some common examples of factors found to contribute to the vulnerability of people who have a disability.

Figure 9: Individual Characteristics that can Increase Vulnerability to Abuse

CHARACTERISTICS	CAUSATION
Limited communication skills	This may lead to a person with a disability being perceived as a "safe" victim and also makes it more difficult for the individual to report abuse (Kennedy and Company 1997; Sobsey, 1994)
Learnt over-compliance	A culture of compliance that encourages a desire to please and discourages assertiveness increases vulnerability (Kennedy and Company 1997, Muccigrosso 1991; Community Services Commission of NSW, 1996). Complete dependence on the caretaker for much of daily living doesn't support the development of independence skills. Learned helplessness can restrict people's decision-making skills, increasing vulnerability (Sobsey, 1994; Muccigrosso 1991).
Limited physical mobility	This can give offenders greater access and opportunity (Kennedy and Company, 1997) and can prevent individuals leaving services or abusive situations (Community Services Commission of NSW and Intellectual Disability Rights Service, 2001).
Low self-esteem	People who develop little sense of personal power can easily become victims as they are used to having others run their lives.

CHARACTERISTICS	CAUSATION
Low income or access to resources	Limited income or access to resources can create dependency on caregivers and limit personal capacity to leave abusive situations, particularly circumstances of domestic violence (The Roeher Institute, 1995a).
Limited opportunity for sexual or intimate relationships	"If you don't know what abuse is, have not had any sex education, how do you know that what is happening to you isn't right and should be stopped. In addition some people with a disability may have an unrealistic view that everyone can be trusted" (Muccigrosso 1991). Some researchers suggest that limited opportunities for sexual experiences pre-dispose women with a disability to abuse, for example: "Disabled women [sic] have had few healthy sexual models against which to measure our/their selves. Because of a longing to feel intimacy with another person, we/they sometimes engage in unhealthy and even lethal activity, rather than shut off from human contact." (Womendez & Schneiderman, 1991).
Lack of understanding abuse and individual rights	Lack of knowledge with regard to rights and what constitutes abuse is considered a contributing factor to the high incidence of abuse of people with a disability. In particular, the low level of awareness amongst people with an intellectual disability with regard to sexuality issues and sexual rights has been well established (Community Services Commission of NSW and Intellectual Disability Rights Service, 2001).
Physical detachment	Women with a physical disability have often had to dissociate body parts in order to deal with catheters, bathing, relieving of the bowels etc. This can contribute to a high tolerance for abuse. In addition, the need to depend upon others for personal care, transport and other assistance creates a situation of vulnerability to abuse by caregivers (Womendez & Schneiderman, 1991).

Despite the caution regarding an overemphasis on individual factors in abuse, there has been a substantial amount of work undertaken to identify causal factors and develop resources that reduce individual vulnerability. These include the following (adapted from various sources including Sobsey, 1994; The Roeher Institute, 1994; 1995a; 1995b):

- **Increasing awareness of rights** and how to report abuse, including assertiveness training and empowerment.
- **Enhancing communication**: strategies include increasing access to facilitated communication technology, providing access to assistance and skills development eg speech therapy services, rehabilitation experts, increasing staff training in non-verbal communication and the use of communication aides.
- **Mobility and freedom of movement**: strategies to overcome mobility restrictions enable increased independence and the capacity to leave aversive service or family settings.

- **Reducing compliance:** teaching parents, educators and care providers to ensure that compliance is not inadvertently taught to children and adults with a disability has long-term benefits with regard to individual resilience.
- **Building knowledge and skills**: particularly with regard to sexuality and the development of healthy sexual relationships, financial management and functional skills that increase independence.
- **Increasing self-esteem:** providing meaningful opportunities for people with a disability, addressing disadvantage, access to assertiveness and self-worth programs.

Although the majority of work in building resilience has focused on people with intellectual disability, comparable work has looked at the needs of women with a physical disability. For example, the USA National Study of Women with Physical Disabilities (Young et al,1997) recommends steps be taken to train girls and women with disabilities to understand inappropriate touch, including in medical settings, and to learn how to recognise and avoid or resolve abusive situations in the family and in the community. Important elements in this training are informing women that they do not need to tolerate abuse and linking them to community resources that could help them expand their options for removing violence from their lives.

In Australia, there are a substantial number of training resources, programs and packages available for providing information and skills development to people with a disability to self-protect against abuse. Examples provided below include information developed for women with disabilities under the Partnership Against Domestic Violence Initiative; and the Feel Safe program developed in Western Australia.

Each State and Territory has undertaken the development of resources and programs and the provision of training to people with a disability, including sexuality training, training in rights and recognising abuse. Resources have also been developed by other government and non-government agencies including partnership approaches to violence against women.

The degree to which programs and training strategies have been effective is difficult to assess. Sobsey (1994) and Muccigrosso (1991) note that there have been few empirical evaluations of the effectiveness of individual education programs for abuse prevention. Australian jurisdictions report little or no evaluation, research or monitoring of these activities.

Example 6: Domestic Violence Information for Women with Disabilities (Aust.)

Partnership Against Domestic Violence is a joint Commonwealth/State initiative that included the development of products for women with disabilities that aim to:

- Raise awareness about domestic violence among women with disabilities and the broader community.
- Make detailed information about domestic violence available to women with disabilities – either by the resources themselves or by letting them know who they could contact.
- Make information available to service providers about the issue of domestic violence and

about how to provide an effective service to women with disabilities.

- Provide information in various degrees of detail so women can access information that suited their needs; provide information in a range of formats – including a poster, a print based information booklet, a picture story, an audio tape and on the Internet; and
- Provide information that is distributed widely in places that most women with disabilities are likely to go – including mainstream outlets, targeted disability and domestic violence services, information and referral services.

Reference: Information products for women with a disability on domestic violence are available from the Commonwealth Office of the Status of Women, visit: www.osw.dpmc.gov.au

Example 7: The Feel Safe Video (WA)

The Disability Services Commission of Western Australia has developed a video program for the Feel Safe program to help people with communication, cognitive, reading and intellectual disabilities avoid abuse and exploitation. The Feel Safe program is recognised as giving people with disabilities the skills and problem solving techniques to apply to a wide range of situations, locations and unplanned, unrehearsed events. The video vignettes, using people with intellectual disabilities as actors in 'real life' situations, are designed to complement the Feel Safe programs and further enhance the learning process, increase group participation and acknowledge the day to day reality of the participants lives.

Reference: Disability Services Commission, Western Australia (survey response)

Another difficulty is the lack of information regarding the reach of training programs and initiatives. The relative proportion of people with a disability who receive appropriate training is generally unknown. The delivery of training such as sexuality programs to people with an intellectual disability requires highly skilled educators who may be more readily accessed in metropolitan areas than rural and remote areas. There does not appear to be a comprehensive approach to ensuring that within local communities the appropriate range of programs is available.

A broad approach to improving the knowledge and functional ability of people with a disability in areas such as self-esteem, sexuality and communication is likely to have some positive impact on building resilience to abuse within this population. School-based education may be particularly effective; this requires collaboration with education departments and providers.

KEY FINDINGS

15. Building individual resilience has been consistently identified as an important approach in preventing abuse. However, there has been limited evaluation of the effectiveness of specific strategies such as training programs developed in Australia.
16. Given the diversity of the population of people with a disability there may be economies in a national approach to sharing resources and curriculum and improving access to skilled training providers who can deliver training programs to specific groups (eg people with different types of disability). Such an approach would require coordination and maintenance, and would also need to be accessible to service providers, advocacy organisations and consumer groups.

2.4 FAMILY SUPPORTS AND INTERVENTION

In the literature on disability, "family" is sometimes understood to include not only parents, husbands, boyfriends and other relatives but to encompass friends, neighbours and care-givers. It has been suggested that the notion of family includes the range of people (paid and unpaid) upon whom individuals may often depend to provide them with assistance in carrying out their everyday lives (Health and Welfare Canada, 1993b cited in The Roeher Institute, 1994).

In the family environment, stress has been linked to abuse and violence in research regarding domestic violence, the abuse of children, older people and people with a disability (Ammerman, 1997; Glendenning, 1999; Senn 1988 cited in Sobsey, 1994).

It would be an error to stereotype all families that include a member with a disability as being high risk. Not all of these families suffer from isolation, excessive stress etc., and each family is unique (Sobsey, 1994). However, a number of research studies have found that families of young adults with a disability often experience higher stress than other families (Tichon, 1998).

The following factors have been identified by a number of authors (Tichon,1998; Sobsey,1994; The Roeher Institute, 1994; 1997) as contributing to an increased likelihood of abuse within the family setting:

- Long-term nature of the dependency of the parent-child relationship and ageing issues for the parent.
- Disruptions in attachment between family members.
- Family member attributes, such as substance abuse, history of previous violence.
- The presence of and long-term nature of challenging behaviour.
- Isolation and a lack of knowledge regarding sources of help contributing to frustration and burnout of parents.

Significantly more research, analysis and development of family-centred interventions have been done in the area of child abuse and elder abuse than in regard to people with a disability (Tichon, 1998). However, success factors that are relevant to improving the prevention of family-based violence against people with a disability include the following (developed from Sobsey, 1994; Tichon, 1998; Tomison 1997; The Roeher Institute, 1994, 1995b):

- Reducing isolation and stress by increasing the supports available to families, including respite services; home-visiting programs; parenting skills development and assistance with caring roles.
- Supporting families in a way that builds attachment between family members.
- Improving risk assessment skills and identification of abuse and appropriate response guidelines and strategies.

- Improving the supports available to professionals to assist their response to abuse (professionals are more likely to report abuse if viable response options are available and there are clear reporting and action procedures).
- Developing appropriate intervention strategies that are focused on supporting and maintaining the family-unit, particularly given the shortage of alternatives for people with a disability. Prevention strategies targeting families are more effective when participation is voluntary and family members have positive feelings about their involvement.
- Improved linkages with child protection services for children with a disability.
- Improving access to community supports and services including good medical care, housing, transport and generic community services.
- Identification and intervention to address contributing difficulties such as substance abuse, low self-esteem and history of abuse.
- Increasing access to employment services and day programs for adults with a disability.
- Greater multi-disciplinary collaboration and professional development to improve access to generic community supports for people with a disability.

Tichon (1998) identifies a gap in Australian State/Territory legislative protection for adults with a disability, living in a family environment. There is no legislative protection for non-spousal domestic violence perpetrated against an adult.

CSDA-funded strategies to support families through community-based assistance include:

- Services to assist the child and family to address the impact of disability e.g. therapeutic services,
- Early childhood intervention and behaviour support and intervention;
- Respite care services (centre-based and in-home)
- After schools hours and vacation care programs;
- Local area coordination and case management to link families and carers to generic community services, resources and supports;
- Carer support networks and resource agencies; and
- Carer and parenting skills training.

Issues that have been identified with regard to family-centred supports include:

- Particular supports, such as parenting training, appear to be provided on an ad-hoc basis and may not be available at a time when risk is identified and may be addressed (analysis of State/Territory programs).
- There is high unmet need for respite services and significant opportunities for improving these services. For example, families have more choice of carers through in-home or peer respite than through centre-based respite (Productivity Commission, 2000).

- Access to generic community services can be limited by the capacity of these services to cater to families, children's and adults with a disability. For example, child care services and vacation care programs often have difficulty catering to children with additional support needs.
- Service coordination is inconsistent across jurisdictions.
- Links between services including mental health and child protection services have been identified as problematic in some jurisdictions.

Tichon (1998) suggests that intervention models for family-based abuse of adults with a disability might build on existing family-centred intervention approaches to child abuse in Australia or might borrow from community-based models developed overseas (e.g. multi-disciplinary teams funded to address the abuse of older people in the USA and Canada - see Practice Example below). As the community learns more about abuse of adults with an intellectual disability by family caregivers and gains more experience working with both victims and abusers, procedures can be evaluated and revised to respond to the unique circumstances of this group (Tichon, 1998).

Example 8: Family Support Programs (VIC)

Programs to support families with a child or adult who has a disability in Victoria, include the Making a Difference Program that provides flexible resources to support and strengthen families in providing care to family members; the HomeFirst Program that provides support to people with disabilities to enable them to live as independently as possible in the community; and the Great Breaks Program that provides respite support to carers/ families.

Reference: Department of Human Services, Victoria (survey response).

KEY FINDINGS

17. A range of family and community based supports contribute to reducing stress in those families at risk of violence or abuse.
18. The development of approaches to identifying risk and appropriate family-centred intervention are necessary components in abuse prevention.

3. PREVENTING SYSTEMS ABUSE

"Systems abuse occurs when preventable harm is done to children or adults with a disability in the context of policies or programs that are designed to assist them. Individual harm occurs when the capacity of a service system to provide adequate supports is compromised by sub-optimum services, policies that fail to prevent neglect or abuse, or system failures that prevent individual needs being met."' [Cashmore et al, 1994].

Systemic factors in the abuse of people with a disability have been repeatedly highlighted in research and discussion. Common themes include:

- the failure of society to provide adequate services and supports to people with a disability;
- the poor quality of many of the services that are provided;
- the degree to which service systems have disenfranchised and segregated people with a disability;
- the failure of systems to recognise and respond to abuse; and
- the lack of resources for addressing problems in service systems

(List adapted from Sobsey, 1994; Conway et al, 1995; The Roeher Institute, 1995a; 1997).

In examining these issues, attention has been paid to the broad socio-political environment that determines the priority given to serving people with a disability and the available resources. The responsibility for meeting the needs of people with a disability is a social one (Sobsey, 1994). The role of government includes identifying the needs, effective ways to meet the needs and delivering services in an accountable and responsible way. Creating greater recognition within the broader community with regard to the rights of people with a disability to adequate services and supports is a key strategy to addressing the lack of resources and priority that have been a feature of service systems in the past.

Recurring themes regarding system inadequacies in the disability service sector have much in common with the causes of systemic abuse described by Cashmore et al (1994) in a major review of abuse and neglect in children's services in NSW, they include:

- Lack of resources
- Gaps between policy and practice
- Lack of coordination and consistency
- Inadequate guidelines
- Lack of specialised skills
- Lack of support for staff
- Lack of information
- Lack of a voice for children
- System for system's sake
- Structural insulation

Cashmore et al (1994) and Sobsey (1994) have identified strategies to prevent systems abuse such as increasing accountability at all levels, improving coordination between agencies, making informed decisions regarding resource allocation and individual needs, ensuring that programs are focused on individual outcomes and that there is a strong consumer voice.

This section of the review will focus on systems that operate at the administrative level (i.e. across jurisdictions). The section following this one will look more closely at service level initiatives and issues. Strategies to address systems abuse include:

3.1 SYSTEMS DEVELOPMENT.

3.2 ENSURING QUALITY.

3.3 SERVICE MONITORING.

3.4 CONSUMER EMPOWERMENT.

3.4 INCREASING PROFESSIONALISM.

3.1 SYSTEMS DEVELOPMENT

In its simplest form, systems abuse occurs when the needs of people with a disability are not recognised and essential services are not provided or may be inadequate, inappropriate or poorly coordinated.

Service Access

Service access systems typically include individual assessment to determine need and relative priority as well as regional or population based needs assessment. The individual assessment is a mechanism to determine risk or vulnerability to abuse, which may then be considered when eligibility and priority status is determined.

Improving the degree to which disability-related support services are available, affordable, portable and subject to consumer control so that people with disabilities are not required to participate in services that may involve risks, has the capacity to decrease the risk of abuse (The Roeher Institute, 1995a; Sobsey, 1994).

An investigation into demand and unmet need for disability services across Australia in 1997 identified significant issues in access to residential, respite and day program services (Australian Institute of Health and Welfare, 1997). Dissatisfaction with access to these services has been identified more recently in the *National Satisfaction Survey of Clients of Disability Services* (Productivity Commission, 2000).

Meeting individual needs is a key theme in abuse prevention. Elements of good practice in meeting individual needs include individual assessment of need and priority; providing tailored support and flexible options; capacity to change the support provided in response to changing needs or circumstances; and monitoring and evaluation of individual outcomes and satisfaction.

Recent approaches within CSDA jurisdictions to improving access to services and funding systems include the development of a case-based funding system for employment services based on independent needs assessment and consumer

choice (where more than one service is available). This system has been trialed and will be further refined before full implementation.

NSW has developed a Services Access System, designed to ensure that the NSW Ageing and Disability Department can respond promptly and effectively to requests for community based supports from people with disabilities, their families and carers. The focus is on individuals who have been unable to access adequate or suitable support from existing service providers and/or existing community resources; and are at-risk with regard to maintaining current independence or support arrangements. Other States and Territories have developed strategies to better manage access to services; for example, the Department of Disability Services in Queensland has developed a state-wide needs register.

Example 9: Disability Service Access System (NSW)

A Service Access System (SAS), has been developed in NSW to ensure that the Department of Ageing, Disability and Home Care can respond promptly and effectively to requests for community based supports from people with disabilities, their families and carers. The focus is on individuals who have been unable to access adequate or suitable support from existing service providers and/or existing community resources and are at-risk with regard to maintaining current independence or support arrangements.

Other States and Territories have developed strategies to better manage access to services for example, the Department of Disability Services in Queensland has developed a state-wide needs register.

Reference: Department of Ageing, Disability and Home Care, NSW; Department of Disability Services, Queensland (survey responses).

Coordinating Services

A significant issue for people with a disability living in the community can be the need to investigate, access and coordinate a range of supports from different sources. Access to services can be limited by the difficulties individuals face with regard to getting appropriate information and effective assessment to determine access and need as well as having the capacity to manage their relationships with service providers. Across human and community service sectors, within Australia and overseas, more attention is being paid to the need for streamlining pathways into services, links between services and providing more choice to consumers.

Example 10: Local Area Coordination (WA)

The Western Australia government established the Disability Services Commission across the state to coordinate access to mainstream and specialist services. This provides a single point of access for a broad range of support services that people with a disability may seek. The Commission can work with individuals and families to assess need and preferences identify appropriate services and provide referral or resource brokerage and other forms of assistance with regard to access and coordination of supports. Local Area Coordination provides increased flexibility in service purchasing tailoring the services provided to the individual needs and providing greater choice to the service user. The Productivity Commission (2000) identified Western Australia as having high consumer satisfaction with regard to service coordination.

Reference: Disability Services Commission, Western Australia (survey response) and the Productivity Commission (2000) National Satisfaction Survey of Clients of Disability Services.

Example 11: Service Coordination in Aged Care (Aust.)

Aged Care Assessment Teams assist people obtain a range of Commonwealth funded services to help them continue living in their own home, or enter a residential care facility such as a nursing home or hostel. Teams are usually based at a hospital, geriatric or community centre and can see people in their own home or in hospital. Assessment Teams might include a doctor, nurse, social worker, occupational therapist or physiotherapist. They provide information to help make informed choices about aged care services, including HACC, Respite Care, Community Aged Care Packages and residential facilities.

Reference: Commonwealth Department of Health and Aged Care – see web site www.health.gov.au

Carelink Centres will be established in each of the 53 Home and Community Care (HACC) regions throughout Australia and will be connected nationally through a single 1800 telephone number. Each centre will maintain a comprehensive database of information on services available in the region, enabling staff to provide up-to-date, accurate information in an instant, either in person or by phone. Commonwealth Carelink Centres will provide a central source of information that links health professionals, general practitioners, other service providers, carers and individuals with agencies providing care and support in the region.

Reference: Commonwealth Department of Health and Aged Care – see web site www.health.gov.au

Reforming Funding Frameworks

Cashmore et al (1994) and Sobsey (1995) identify that the impact of inadequate resources on services can heighten the risk of abuse occurring within service systems, due to factors such as:

- Increased and unreasonable demands on staff which lead to high staff turnover, poor continuity of care, staff dissatisfaction and potentially resentment toward consumers.
- Increased strain on services that results in crisis management, inadequate planning and review, poor staff supervision and management.
- Insufficient support for individuals that can lead to poor individual outcomes, increased dependence on services and increased dissatisfaction that may lead to increased challenging behaviour in some cases.

Approaches to funding services within the broader human service sector are increasingly allocating resources to individuals based on needs assessment and/or individual choice.

The majority of CSDA funding is administered through block-grants to service providers. Equity in funding arrangements has been identified as a key aspect to quality and effective service delivery in a number of program reviews (Victorian Auditor General, 2000; NSW Audit office, 1999). Problems identified with historical approaches to funding include:

- There is inequity in the way that funding is allocated, as it is not linked to needs assessment. Access to service vacancies is therefore not adequately linked to assessed need, priority or risk (Audit Office of NSW and Ageing and Disability Department, 2000).
- There is high unmet need for some services across jurisdictions (Australian Institute of Health and Welfare, 1997; Productivity Commission, 2000).
- Funding systems lack the capacity to respond to changing individual needs and to people in crisis (Audit Office of NSW and Ageing and Disability Department, 2000).
- Funding is not linked to performance outcomes or quality standards (Audit Office of NSW and Ageing and Disability Department, 2000).
- Service viability can be compromised as individual consumer needs change or operating costs increase; supplementary funding or viability review is reactive and fails to address underlying issues (Audit Office of NSW and Ageing and Disability Department, 2000).

Ensuring adequate resources are provided to meet identified needs is not a static process - individual needs change, service costs vary, the availability of supports fluctuates etc. Thus it is an ongoing process of assessment and review.

The Audit Office of NSW and Ageing and Disability Department (2000) identified the need for particular funding decisions to be:

- Supported by assessment of individual needs, determination of eligibility and priority of access.
- Informed by breaches of funding agreements, unresolved consumer complaints, targeted reviews and regular monitoring decisions.
- Output-focused, reflecting the needs of individual clients.
- More flexible to take account of changing client needs.
- Able to take into account that clients do not only need accommodation, but require a range of specialist support services programs and independent representation.

Australian State and Territory governments have established purchaser/provider arrangements with non-government providers of disability services. There is increasing consistency between the way in which government and non-government services are funded and monitored, however this is an area of ongoing development.

The Australian Institute of Health and Welfare (2000) has summarised the changes in funding models in disability services across Australian jurisdictions. The Institute identifies that although block grant funding to service providers is still in place in several jurisdictions, it is being progressively replaced by output-based and/or consumer-based funding in most cases. The Institute finds that outcome-based funding is emerging as a new model and there is a general need for further development work to establish ways of linking funding to outcome achievement. An example of improved links between funding and outcome achievement is the case-based funding model currently being implemented by the Commonwealth (see practice example below).

The Institute also found that consumer-based funding models are in place in most jurisdictions. A number of State/Territory administrators have flexible funding and brokerage services to provide specific types of supports. For example, the Disability Services Commission in WA provides flexible respite care funding that can be used to purchase supports directly or through service provider. These typically involve brokerage arrangements, under which funds for the individual are managed by an agency that may provide services directly and/or purchase services from other providers, with consumer involvement in decision-making. There are some examples of direct consumer funding in place, however no examples of voucher funding were identified.

Example 12: Case-Based Funding Trial for Employment Services (Aust.)

A case-based funding system is being trialed and developed by the Commonwealth Government. Under the case based funding system, payments to service providers are linked to employment outcomes achieved for the individual. The Commonwealth seeks to purchase employment outcomes that are measurable but acknowledges that the achievement of outcomes takes time. There are a series of part-payments at milestone points in the service delivery process including an interim outcome payment for initial employment achievements and a final outcome payment when durable employment is achieved. Maintenance payments purchase ongoing support for those consumers that require it. The purpose of the case based funding trial is to test this alternative funding model for specialist disability employment services and assess its effectiveness in improving service delivery that focuses on quality employment outcomes. The objectives of the case based funding trial are to:

- Examine the impact of case based funding on employment outcomes for the range of job seekers including disability type, location and level of assistance required;
- Assess the suitability of the classification tool in placing job seekers into differing funding bands reflecting broad support requirements;
- Determine the appropriateness of the trial funding levels in meeting the costs incurred;
- Assess the impact of case based funding on service viability and responsiveness; and
- Identify financial incentives and disincentives for improved performance in different service types, sizes and various locations.

The case based funding trial is being undertaken in a number of trial regions across the country; there is at least one trial region in each state and territory. Both open and supported employment service providers funded by the Department of Family and Community Services were invited to participate in the trial, participation is voluntary.

Reference: Commonwealth Department of Family and Community Services (2000) *Case Based Funding Trial Evaluation, available from:* www.facs.gov.au.

Performance Measurement

Measuring performance relies on data collection within service systems in order to inform planning and decision-making. The Audit Office of NSW and Ageing and Disability Department (2000) recommends that:

- Data needs to inform evaluation of performance and have its accuracy verified.
- Data needs to be drawn from all relevant sources.
- Data needs to cover existing clients, vacancies and unmet demand.
- Systems need to be integrated, and consistent across service providers.

In Victoria, there has been considerable development of state-wide information systems for disability services in recent years – for client information, management of client funds and contract monitoring. Information to monitor service quality and performance is less well-developed or well-integrated at regional levels (Victorian Auditor General, 2000).

Nationally, the development of the CSDA Minimum Data Set is a major component of sector reform in the area of performance and outcome measurement. The National Consumer Satisfaction Survey is another example of new approaches to performance measurement. Queensland has expressed an intention to undertake a state-wide consumer satisfaction survey.

The measurement of individual outcomes for consumers is also receiving increased attention. For example, Tasmania has initiated a Personal Outcomes Measurement Project and Victoria has auspiced a project to develop a Quality of Life Assessment Tool.

Services provided under the CSDA are also undergoing substantial systems development. As the nature of services and systems change, new challenges for abuse prevention will evolve.

Example 13: Outcomes Monitoring Project (TAS)

A Working Party within Disability Services in the Department of Community and Health Services has been examining the feasibility of evaluating services in terms of the extent to which individualised agreed client outcomes are being met. The Working Party has been considering options for differentiating between quality of life indicators and quality service process indicators and how introduce a direct link between individual quality of life and performance based funding levels to service providers. A pilot project involving five service provider organisations commenced in 1999 to trial Personal Outcomes Measures based on those developed by the US Council on Quality and Leadership in Supports for People with Disabilities.

Reference: Department of Community and Health Services (survey response).

KEY FINDINGS

19. Contemporary developments in the way services are provided to people with a disability have the potential to contribute to abuse prevention. For example:

- Individual and portable funding that allows individuals to change services and change the supports that they receive, increasing independence and reducing the risk of abuse.
- Defensible and individually focused funding or resource needs assessment.
- Assessment and access mechanisms (that provide access to supports based on relative need and available resources) involve risk assessment including the potential risk of becoming either a victim of abuse or an offender.
- The development of performance data to inform planning and decision-making (which may include individual outcomes with regard to increased resilience to abuse, reduced risk of violence or harm).

3.2 ENSURING QUALITY

Broad Approaches To Quality

Approaches to ensuring quality within human service systems are not as easily defined as those in industrial settings such as manufacturing, nor as advanced as those in highly regulated services such as hospitals. Terms such as *quality improvement; quality assurance; quality frameworks, systems or processes,* have a diversity of meaning within the disability services sector. This review examines broad approaches to quality within human service systems before looking more specifically at current practice within the CSDA service sector.

Providing quality services is integral to any framework for reducing the risk of abuse for people with a disability. The systemic nature of much of the abuse perpetrated against people with a disability; the impact that this has on people with a disability as a population; and the interaction between service culture, environment and relationship with consumers; are all factors to consider when examining prevention.

The prevention of abuse within service systems is becoming a core component of modern quality assurance systems in human services. For example, the United Kingdom government in developing National Standards for Social Services (including services for people with a disability) identifies the need to address abuse through overall quality improvement: *"…everyone will be safeguarded against abuse, neglect or poor treatment while receiving care. Standards will be clearer, checks will be tighter and the regional Commissions for Care Standards will have strong and swift powers to put a stop to any abuse where it occurs." (UK Department of Health, Modernising Social Standards, 2000).*

The prevention of abuse within other service systems has also been strongly linked to broad approaches to enhancing the quality of care, and improving the outcomes of care in research literature (see for example: Nolan, 1999). Common features of quality systems being developed for human service systems in Australia and overseas are described in the table below.

Figure 10: **Good Practice Elements Of Quality Systems**

FEATURES	COMMON ELEMENTS	EXAMPLES
Independent Assessment, Monitoring and Review against Quality Benchmarks	⌖ Accreditation/Certification of approved providers ⌖ Legislated standards of practice and/or service outcomes ⌖ Assessment undertaken by approved agencies operating independently of both purchaser and providers ⌖ Continuous quality improvement is built into quality processes ⌖ Increased staff training and qualification requirements	⌖ The UK Social Standards Act introduces common national standards for all social services. ⌖ Long Day Care Centres In Australia must be accredited by the Child Care Accreditation Council and be licensed by State/Territory Child Care Licensing agencies (Minimum Practice Requirements) ⌖ Residential Aged Care Facilities must be accredited by a Certification Agency against standards prescribed by the Aged Care Act (1997) in a continuous improvement paradigm
Consumer participation and complaints	⌖ Consumer participation in assessment and review of services ⌖ External consumer complaints mechanisms ⌖ Independent complaints mechanisms with power to investigate and/or trigger a review of services	⌖ The UK Care Standards Bill includes an independent complaints mechanism for social services ⌖ USA Elder Abuse Prevention Network has State Agencies that handle consumer complaints regarding aged care services ⌖ The Australian Aged Care Complaints Scheme is confidential and investigates all consumer complaints. Consumer participation is mandatory in the residential care accreditation system
Supports and Resources	⌖ Information for consumers ⌖ Guides, manuals and codes of practice for service providers	⌖ Residential Aged Care Services are provided with a comprehensive Aged Care Manual to assist meeting the standards ⌖ The Australian Aged Care Sector has developed Code of Conduct and Ethical Practice
Independent funding or resource needs assessment	⌖ Support needs assessment and resource allocation is undertaken by an agency independent of the purchasing agency or provider and is subject to appeal or review.	⌖ Resident Classification Scales (Aust. Aged Care Reforms) ⌖ Workability Assessment conducted by Centrelink prior to eligibility for Commonwealth Employment Services
Higher penalties for breaches	⌖ Sanctions against services in breach ⌖ Protocols for appointing administrators, closing services etc ⌖ Public information regarding breaches	⌖ Sanctions are applied to Australian Residential Aged Care Facilities that are assessed as non-compliant against the Aged Care Standards.

Examples of broad approaches to ensuring quality in a number of Australian and International human service sectors are provided below for consideration.

Example 14: Broad Approaches to Ensuring Quality in Australia and Overseas

ACCREDITATION OF RESIDENTIAL AGED CARE FACILITIES (AUSTRALIA)

The Commonwealth Department of Health and Aged Care has introduced an Accreditation system that is compulsory for all residential facilities eligible for Commonwealth funding. The principles and standards required for accreditation are prescribed by the Aged Care Act (1997). An independent certification agency has been established which undertakes an on-site audit of services over several days using accredited assessors. The audit is preceded by an extensive internal audit undertaken by service providers. Components of the system include Aged Care Standards, Certification Agency, Resident Classification Scale, professional standards, sanctions against services in breach, and an Independent National Complaints Resolution Scheme.

Reference: Commonwealth Department of Aged Care, further information available from www.health.gov.au.

MODEL REGULATIONS FOR SERVICES FOR PEOPLE WITH DEMENTIA

Hyde (1995) undertook a review of regulatory frameworks for the care of People with Dementia in Assisted Living and Residential Care Facilities across the USA. The review was comprehensive and included the development of model regulations to serve this population. A summary of the key components of model regulations is provided below:

- Licensing, registration or certification of specific service types.
- Monitoring of services through visits and inspections undertaken by personnel that receive extensive training.
- The capacity for waivers and demonstration programs within regulations, in order not to inhibit innovation.
- Programs are overseen by expert advisory groups with consumer representation on advisory panels within services and state agencies.
- Staff training and qualifications.
- Legal protection for resident's rights.

Reference: Hyde (1995) *Serving People with Dementia: Regulated Assisted Living and Residential Care Setting*,

LICENSING AND ACCREDITATION OF LONG DAY CARE SERVICES (AUSTRALIA)

State/Territory Regulations require long day care services to be licensed by the appropriate State/Territory government agency. The regulations include standards with regard to a range of service delivery characteristics such as the environment, staff-to-child ratios, staff qualifications and screening, the program, health and hygiene, food preparation, information that must be provided to parents, and emergency procedures. Compliance with the regulations is monitored by State/Territory licensing agencies or funding bodies, usually through on-site visits (both scheduled and unscheduled) in addition to reporting and monitoring requirements. Services are required to meet the regulations in order to operate licensed child care services, regardless of funding sources.

In addition to regulations, to be eligible to offer families Commonwealth rebates long day care services must comply with a Quality Improvement Accreditation System. This system operates at a

national level, has a focus on continuous quality improvement and accredits services for 1 to 3 years through an assessment undertaken by the Child Care Accreditation Council.

Reference: National Child Care Accreditation Council (2001) *Quality Improvement and Accreditation Handbook*, further information available from www.ncac.gov.au

THE NATIONAL CARE STANDARDS COMMISSION (UK)

The National Care Standards Commission will be established from 1 April 2002 as a non-departmental public body to take on the regulation of Social Care and private and voluntary health care in England. Inspectors and support staff will transfer from health authorities and local authorities to the NCSC to regulate the following services:

- Care Homes including Children's Homes
- Domiciliary Care Agencies
- Residential Family Centres
- Voluntary Adoption Agencies and Independent Fostering Agencies
- Private and Voluntary Hospitals and Clinics
- Nurses Agencies
- Day Centres

It will also inspect local authority fostering and adoption, and welfare aspects of boarding schools. The Commission will regulate and inspect these services against national minimum standards; and investigate complaints.

Reference: UK Department of Health (2000b) *A Quality Strategy for Social Care,* UK Government Publication, available from: www.doh.gov.uk/scg/qualitystrategy/index.htm

Quality Assurance In CSDA Jurisdictions

All States and Territories have introduced quality systems that are based on the implementation of, and compliance with, standards for disability services. Some of the common features of these systems include their link to national Disability Services Standards; integration with purchaser/provider arrangements; expectation that all providers will meet the standards; and provision of resources to assist providers to adopt practice and assess conformity.

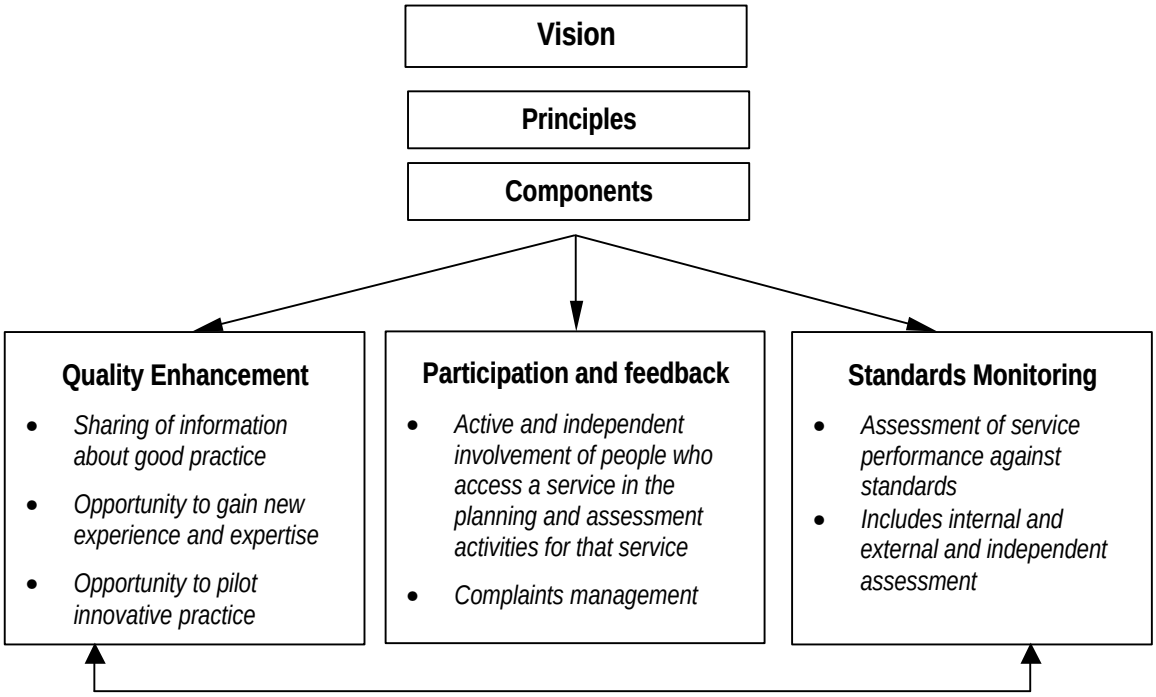
There are some important differences between the systems established in each jurisdiction, including:

- Balance of initiatives and mechanisms to promote 'quality improvement' versus 'quality assurance'.
- Processes for assessing extent of compliance with standards and for promoting compliance with the standards.
- Processes for promoting and enabling consumer involvement in quality assurance processes.
- In some jurisdictions, Disability Service Standards have been tailored for different service types eg residential services, respite services etc.

- In some jurisdictions, additional Disability Service Standards have been developed in relation to the prevention of abuse and neglect, staff qualifications and training, and recognition of cultural diversity.
- In one jurisdiction (Western Australia), disability services legislation has provided a platform for the introduction of penalty provisions for abuse of people using services.

The development of integrated quality systems has been undertaken in some CSDA jurisdictions, in collaboration with service providers and consumers. An example is the Queensland Framework for the Disability Sector, outlined in the diagram below.

Figure 11: Components of the Queensland Disability Services Quality Framework



There is currently no requirement for accreditation of disability services in any jurisdiction, although some service providers choose to obtain accreditation under an alternative quality assurance system. Commonwealth-funded disability employment services will be required to be accredited under a new quality assurance system that is currently being piloted (see practice example below). Some States and Territories reported that accreditation issues were being considered.

The expectations on service providers to prevent and respond to abuse are dealt with differently in the standards frameworks in each jurisdiction. Two jurisdictions have specific standards relating to abuse prevention, while others refer to abuse prevention within the context of other standards. The degree of detail in the supporting standards or assessment criteria also varies across jurisdictions.

Example 15: Proposed Quality Assurance System - Commonwealth Disability Programs

The Commonwealth Department of Family and Community Services is currently piloting a new quality assurance system for CSDA-funded employment services. In order to be eligible for funding, services will be required to achieve certification through independent certification agencies that are licensed by JAS-ANZ. Underpinning the certification process are the national disability service standards and additional standards relating to the skills and competencies of staff and the protection of human rights and freedom from abuse. Key Performance Indicators (KPI) have been developed for the standards and services will be required to provide evidence with regard to how they meet the standard as measured by the indicators.

A case-based funding model is also being trialed in addition to new arrangements with Centrelink for the assessment of people with a disability seeking access to employment support. The assessment includes the provision of information regarding the range of appropriate services available in the local area. The use of Centrelink aims to provide choice to people with a disability and probity in the assessment of support needs and service options. The case-based funding model seeks to tailor the funding available to the individual's support needs and provide portability of funding across services.

Reference: Commonwealth Department of Family and Community Services (2000) *A proposed quality assurance system for disability employment services*, available from www.facs.gov.au.

Self Assessment

There are a variety of ways used in assessing the achievement of quality standards by organisations. These assessment approaches generally employ one or a combination of self-assessment and/or external assessment methods. The CHASP model developed for the Community Health sector is an example using both approaches, with an external review/assessment following a self-assessment process, and is proven as an effective and reliable quality assessment method. Childcare service standards are also assessed externally following a self-assessment process that prepares services for the external assessment.

Self-assessment is often viewed in human service settings as a cost-efficient method of quality assurance, and has the advantage of creating knowledge and expertise in implementing quality standards, quality assurance and quality improvement within organisations that self-assess. However, while self-assessment is an important approach, using self-assessment alone does not ensure the best quality outcomes. Reasons for this include that the level of expertise and knowledge of implementing quality standards developed within an organisation are not determined and can be relatively low, and resulting assessments can vary considerably in quality and accuracy. Furthermore, self-assessment used alone does not expose organisations to comparison with the wider service system. Consequently, the most robust approaches employ a combination of self-assessment and external review.

Promoting Best Practice

International examples of promoting best practice include national centres for excellence and best practice. These centres serve to identify, review and promote examples of good practice and innovation.

In some Australian jurisdictions, promoting and ensuring quality includes elements that are additional, but complementary to, those associated with compliance with quality standards. These elements are designed to promote service improvements through strategies to promote innovation and 'best practice'; to support professional development; and to share information across the sector.

States and Territories have adopted a range of approaches to promoting best practice in disability services. These include encouraging the accreditation of services; establishing formal structures within Departments to promote best practice initiatives; providing specific funding to service agencies to develop/pilot best practice models; and to disseminate information about existing best practice.

The Productivity Commission (2000) National Satisfaction Survey of Clients of Disability Services identifies potential examples of superior performance across jurisdictions, including:

- The use of community and public facilities by users of accommodation services in South Australia and the Australian Capital Territory.
- The relationships and friendships enjoyed by people with a disability in Queensland and South Australia.
- The low staff turnover in Tasmania and South Australia.
- Service coordination in Western Australia and Victoria.

Example 16: Approaches to Promoting Best Practice (Various)

UNITED KINGDOM SOCIAL CARE CENTRE FOR EXCELLENCE

A national Social Care Centre for Excellence will be established in Britain as a core component of the Quality Strategy for Social Care, the centre will be responsible for:

- Identifying and prioritising the need for research;
- Promoting and commissioning reviews of research to underpin quality services; and
- Drawing up standards for research review.

BEST PRACTICE FUNDING (AUST. DISABILITY SECTOR – VIC)

The Victorian Department of Human Services provides specific funding for Best Practice/Quality Improvement activities. Funds are used to:

- Encourage service providers to promote innovative and exemplary practices;
- Produce information sheets and documentation for the sector;

- Conduct best practice forums, conferences etc. with national and international input;
- Establish a clearing house/Internet home page to disseminate best practice.

Other documents supporting best practice include the Best Practice Newsletter and Best Practice Forum booklet.

Reference: For more information contact the Department or visit www.dhs.vic.gov.au.

INDUSTRY DEVELOPMENT (AUST. DISABILITY SECTOR – NSW)

An Industry Development and Analysis Unit has been established in ADD, its focus being implementation of an industry development strategy that will help deliver efficient and quality outcomes for people with disabilities in a mixed economy of care. The most relevant elements of the strategy are:

- To analyse trends and report on performance within a national framework; and
- To promote continuous improvement in service provision. Outputs include:
- A quality assurance framework.
- Studies and evaluations of innovation and how they inform "best" practice.
- A web-based strategy that links evidence of innovation and best practice to state, national and international information.
- A professional development strategy.
- Strategies to improve corporate governance in the funded sector.

Reference: For more information contact the Departmental or visit www.add.nsw.gov.au.

QUALITY FRAMEWORK (QUEENSLAND)

The Quality Framework for disability services in Queensland includes a component on Quality Enhancement that provides for sharing of information about good practice; opportunities to gain new experience and expertise; and opportunities to pilot innovative practice.

Reference: Queensland Framework for the Disability Sector, Dept. of Disability Services, QLD.

Sanctions

Currently sanctions against disability services are rarely applied. The capacity to sanction services is limited by current legislation and the potential social impact of closing services that do not comply with quality standards.

The need for swift and decisive action when services are not compliant with quality standards has been identified as a core component of emerging quality assurance systems in human services (UK Department of Health, 2000). An example of how this is applied within Australia is provided in the Practice Example below.

Example 17: Sanctions for Non-compliant Residential Aged Care Services (Aust)

Sanctions are imposed by the Department of Health and Aged Care on approved providers in cases of serious non-compliance. Different sanctions may be imposed depending on the circumstances of the non-compliance. The decision to impose sanctions is not taken lightly and includes consideration of issues such as: whether the non-compliance is minor or serious, whether it has occurred before, and whether it threatens the health, welfare or interests of the residents.

Sanctions action is taken by the Department having regard to the information required to be taken into account by Part 4.4 of the Aged Care Act 1997, which may include reports by the Aged Care Standards and Accreditation Agency. Where reports are publicly available, they may be obtained from the Agency. The Agency's web site is http://www.accreditation.aust.com/reports/reports.html

On this site, the Department publishes its current understanding of:

- the names and addresses of facilities where sanctions are in place;
- the names of the approved providers (operators) of the facilities;
- sanctions action taken under the Aged Care Act 1997 and the reasons for that action; and
- the status of the services.

Reference: **

KEY FINDINGS

20. Analysis of the literature on abuse prevention and quality improvement in the delivery of human services, has identified the following priorities for quality reform in Australian disability programs:

    - Enhancing or tailoring Disability Service Standards to directly address the prevention of abuse and key factors within service environments that contribute to increased risk of abuse.
    - Independent verification and monitoring of quality standards and performance, including more direct measures of output and performance.
    - Independent consumer complaints and investigation mechanisms, with the authority and resources to fully investigate complaints of a serious or systemic nature, and to recommend sanctions where warranted.
    - Supports such as professional training and resources such as policy guides, codes of conduct and research/development activity
    - Higher penalties for breaches or evidence of unacceptable practice.
    - Best practice strategies that include recognition of good practice and innovation and dissemination of examples and information.

    It is recognised that to ensure effective service monitoring, the 'industry' must also own the process. Any development or enhancement of current mechanisms should be undertaken in collaboration with the sector.

3.3 SERVICE MONITORING

Independent, external monitoring of service delivery and consumer issues can contribute to the early detection and prevention of, and response to, the abuse of consumers (Conway et al, 1995; Sobsey1994). In examining the regulation of services for older people with dementia in the USA, Hyde (1995) identifies best practice as monitoring that is State driven rather than complaints-based. Carney (2000) has also identified limitations in relying on individual or complaints-based approaches to improving services in Australia.

Independent monitoring mechanisms can examine service performance with regard to individual consumers, as well as systemic issues. Independent monitoring of this nature is distinct from performance and contract monitoring related to accountability of services. The 1995 review of abuse in residential facilities for people with an intellectual disability concluded that *"…current monitoring of residential services in the area of abuse is clearly inadequate and unacceptable both in terms of service accountability and ensuring that clients are protected from abusive incidents'' (Conway et al, 1995).* The research team recommended that any monitoring mechanism should be independent of both the providers and the funder, have clear sanctions, and must hold management accountable for policy content and implementation and for all incidents of abuse (Conway et al, 1995).

Reports examining quality assurance systems in CSDA jurisdictions have recommended independent verification of service quality, to give stakeholders confidence in the validity and consistency of results (Auditor-General Victoria, 2000; Audit Office of NSW and Ageing and Disability Department, 2000; Assuring Quality, 1997). Additional directions for improvement identified in these reviews include:

- The introduction of more formal service review processes, using a risk based approach and/or independent audit.
- Review processes should include the results of self-assessments, independent verification and monitoring, and more direct measures of output and performance.
- Improve mechanisms to sanction providers in breach of the Disability Services Act and to reverse the conformity status of services where they no longer conform.
- Ensure that government services are subject to the similar performance monitoring processes as funded services.
- That funding should be directly linked to performance to ensure that standards are met.
- Quality assurance systems actively involve consumers in all stages of the process with independent advocacy and training provided appropriately.
- Quality assessments to identify opportunities for continuous improvement.

In Australia, all CSDA jurisdictions have developed processes for monitoring the performance of funded providers, generally as part of the purchaser/provider relationship. Monitoring typically involves an annual self-assessment against the

standards by each service and an external assessment (typically by purchasing agency) undertaken every 3 – 5 years.

In most States and Territories, the framework for performance monitoring is based on the service or funding agreement with the relevant department, which generally specifies the need to conform with the Standards and any specific policies and procedures, as well as performance indicators and reporting requirements.

Performance monitoring in most cases takes the form of monitoring and reviewing the service and funding agreements by the funding department, and occurs at the time of renewal of funding. Few jurisdictions reported additional performance monitoring mechanisms.

In some of these service contracts and performance agreements, there are specific provisions relating to the prevention of abuse, and the rights of the purchaser in the event of possible abuse of consumers.

A number of States and Territories have mechanisms for independent monitoring of services provided under the CSDA that are distinct from performance monitoring related to the funding of services. These monitoring mechanisms are established under separate legislation. As they are generally not developed specifically for CSDA specialist services, there are often some CSDA-funded services that are not included in these mechanisms.

The effectiveness of independent monitoring mechanisms can be compromised in the following circumstances:

- If the coverage and frequency of monitoring visits is insufficient to maintain contact with consumers, to follow-up on issues, or to monitor all eligible outlets (Audit Office of NSW and Ageing and Disability Department, 2000). This may occur due to budgetary constraints.
- Where the monitoring body lacks a clear legislative mandate for acting on information received, lacks the resources to deal with the volume of information received, or are provided with inadequate or incomplete information to enable effective monitoring (Auditor-General Victoria, 2000).

3.4 CONSUMER EMPOWERMENT

One of the key strategies to prevent abuse is the creation of a culture of user empowerment (Daro & McCurdy, 1994; NSW Department of Community Services, 1997; Griffin & Aitkin, 1999). Strategies that can contribute to consumer empowerment include high consumer awareness of rights and responsibilities and participation in decision-making; consumer participation in quality assurance processes; and effective consumer complaints mechanisms.

Consultation with people with a disability has identified that promoting their rights as members of the community and empowering them to exercise these rights are considered priority areas of improvement to enhance the quality of services across CSDA jurisdictions (Productivity Commission, 2000).

In other human service sectors, consumer rights have been given enhanced standing through the adoption of charters or statements (see for example the Aged Care Charter of Residents Rights, described below and attached in Appendix 1). The effectiveness of providing consumers with clear statements of rights has not been evaluated. However, this is typically a component of a broader approach to assisting consumers to understand their rights, recognise abuse, report and complain.

Other strategies to promote high awareness with regard to rights include: consumer training in rights and being assertive; providing advocacy support for people who choose to have assistance in making decisions or communicating with services; and the development of accessible resources and materials to inform people of their rights within the service system.

Shaddock (2000) suggests that a contemporary Australian issue in the development of good practice in the provision of disability services is to understand and apply the meaning of self-determination for people with an intellectual disability. He identifies key concepts in this meaning, which may be summarised as:

- ***"Nothing about me without me" -*** People with disabilities should be involved in the processes and decisions that affect them. Shaddock identified the "who decides survey" designed by self advocates and now part of the evaluation of service in New Hampshire, as an illustration of the many issues about which people with disabilities want to have a say.
- ***"Whatever it takes" -*** This concept challenges the assumptions often built into policies that the rights of individuals and government responsibilities are 'discretionary' and can apply only 'as far as possible'; it is argued that instead we must assert the rights of people with disabilities as inalienable, citizen rights.
- ***"Show us the money" -*** This relates to the need to direct public funds to individuals, and put people with a disability in charge of public funds.

The importance of consumer participation in quality assurances processes is well recognised in the literature and is evident in quality assurance systems in other human service sectors including Aged Care and Mental Health service systems.

Currently NSW, VIC, QLD and the Commonwealth Government have established mechanisms to support consumers in CSDA-funded services to actively participate in quality assurance systems, typically service assessments against the Disability Service Standards. The Commonwealth and NSW systems require services to involve consumers in self-assessment against the standards and provide independent support or training for consumer participation. Brief examples of current mechanisms include:

- Training is available to consumers and advocates; there is also a consumer support information kit and tools provided in a range of alternative formats (NSW).

- Voluntary Client Facilitators assist client participation in the Disability Services Assessment System through a client/carer training and information strategy (VIC).
- A booklet regarding standards assessment is available to consumers in various formats and independent facilitators provided through the relevant department ensure consumer involvement in standards monitoring (QLD).
- Consumers have an independent consultant to assist their involvement in the self-assessment process. Typically consumers complete a consumer assessment and services must demonstrate consumer participation and incorporate the consumer assessment in the overall assessment and action plan (Commonwealth – employment programs).

Example 18: Charter of Residents' Rights (Aust)

AUSTRALIAN COMMONWEALTH AGED CARE ACT

The Commonwealth Aged Care Act (1997) includes a Charter of Residents' Rights and Responsibilities which details the rights and responsibilities of all residents. This includes personal, civil, legal and consumer rights and responsibilities in relation to other residents staff and the residential aged care service community as a whole. This charter must be displayed in all funded services and a copy is usually provided to consumers upon joining a service. A copy of the Charter is provided in Appendix 1.

Reference: Commonwealth Aged Care Act (1997)

Example 19: Consumer Participation in the Mental Health Sector (VIC)

Victoria is considered to be at the forefront of reform and quality systems in the provision of Mental Health services, mechanisms include:

- An annual consumer satisfaction survey and, from this, highlight of particular areas for practice enhancement, e.g. needs of women, needs of people from non-English speaking backgrounds.
- Supporting consumer activity through VICCAG and through the employment of Consumer Consultants.
- The Victorian Mental Illness Awareness Council (VMIAC) receives ongoing funding to support and promote consumer participation across the system.

Reference: Survey responses & interviews (various).

Example 20: Consumer Participation in the Commonwealth Quality Assurance System (Aust.)

As part of the new Quality Assurance system for Disability Employment Services the Commonwealth Department of Family & Community Services has developed a model for certification audits that includes extensive participation by clients of the disability services. Importantly the audit teams include "consumer technical specialists" who are either people with a disability or a family member of a person with a disability. Consumer technical specialists provide a first hand understanding of consumers and their needs and directly engage service consumers to collect evidence with respect to

the Disability Service Standards. Their role and purpose is intended to ensure that service consumers' perspectives are fully incorporated into in the audit process and outcomes. Selection of appropriate people to act as specialists is important and training is required for them to develop a set of identified competencies for the role.

Reference: For more information refer to the Department web site www.facs.gov.au.

KEY FINDINGS

21. Consumer empowerment is enhanced by high awareness of individual rights and skills in representing individual interests. Common strategies to achieve this include:
    - Consumer training;
    - Staff training and service policies/procedures that uphold consumer rights; and
    - The use of a statement or charter of consumer rights as a resource for consumers, service providers and caregivers.
22. The importance of consumer participation in quality assurance processes is highlighted in the abuse prevention literature as contributing toward a culture of empowerment and responsiveness.
23. Better outcomes have been achieved in consumer participation, where government has provided independent support or training for consumer participation and made consumer representation a requirement in the quality assurance system

3.5 CONSUMER COMPLAINTS MECHANISMS

Properly resourced, independent complaints mechanisms are an important element of external service monitoring because they encourage and empower consumers, and because they are messages from the coalface of service provision. According to research, mechanisms outside the authority hierarchy are the most effective, although service providers tend to prefer less intrusive methods (Rindfleisch, 1998 cited in Community Services Commission of NSW, 1996).

The effectiveness of independent complaints mechanisms goes beyond the resolution of individual problems because it allows patterns of problems to be identified. International and Australian examples suggest that complaints handling is enhanced by focusing on resolution of the problem rather than punishment of the transgressor (Community Services Commission of NSW, 1996).

The value of quality complaints mechanisms is widely recognised across many industries and sectors, resulting in the establishment of industry specific complaints bodies in most jurisdictions (see health complaints legislation, ombudsman legislation, telecommunications and utilities ombudsman). The Australian Standard AS4269 1995 outlines the essential elements for an effective complaints handling process.

Current consumer complaints mechanisms across CSDA jurisdictions would be unlikely to conform to the Australian standard. The effectiveness of complaints mechanisms can be enhanced through effective processes to promote the flow of information; adequate resourcing for complaints agencies; ensuring agencies have a range of legislative powers available; and an active, structured approach to facilitating systemic improvements through the review and analysis of patterns of complaints and effective approaches to addressing issues.

Just over half of Australian CSDA States and Territories have complaints mechanisms in place that have some independence from funding agencies. These include the ACT (Community and Health Services Complaints Unit); NSW (Community Services Commission); NT (Health and Community Services Complaints Commission); TAS (Health Complaints Commission) and WA (Office of Health Review). All are independent complaints bodies, established under legislation separate to disability services legislation, have jurisdiction beyond disability services, and each of the bodies has a range of functions and powers complementary to handling individual complaints.

Other options for dealing with complaints in each State and Territory generally include the Ombudsman, Public Advocate or Guardian or Guardianship system, and Community Visitor schemes where these are available. However, none of these bodies are established specifically to deal with complaints about disability services, and so may only play a role where the nature of the complaint fits within their respective mandates.

States and Territories reported other non-statutory options for resolving complaints such as the use of advocacy services (SA, TAS, VIC, WA), dispute and complaint management systems within funding bodies (NSW), and reviews of services by funding departments (NSW, VIC).

The effectiveness of independent complaints mechanisms can be limited by factors such as the range of legislative powers available; lack of resources to deal with workload; and lack of effective mechanisms to promote the flow of information between agencies (Audit Office of NSW and Ageing and Disability Department, 2000). An exclusive or dominant focus on resolving individual grievances may also have limited impact on the systemic factors that contribute to abuse, unless accompanied by an active, structured approach to facilitating systemic improvements (Carney, 2000).

The Commonwealth Department of Family and Community Services is currently developing a national complaints system for consumers receiving support through Commonwealth-funded services (primarily employment or advocacy services). There is the potential for the national complaints mechanism to handle complaints from people with a disability with regard to broader range of specialist services. A national system for handling complaints would require considerable collaboration between Commonwealth and State/Territory Governments, however, a single point of contact has significant potential benefit for people with a disability and administrative efficiencies may be possible.

Example 21: Complaints Resolution Scheme in Aged Care (Aust.)

AUSTRALIAN AGED CARE SECTOR - DEPT. OF HEALTH AND AGED CARE

Australian residential aged care services are required to establish their own comprehensive complaints handling scheme. Although using a service's complaints scheme will generally be the most effective way to resolve a complaint, residents can also take their grievance directly to the Aged Care Complaints Resolution Scheme. This Scheme focuses on resolving complaints by working together with all parties to fix the problem. The Scheme will be overseen by independent Complaints Resolution Committees. The major features of the scheme are:

- It is independent, free and unbiased;
- Residents will be assisted to make effective complaints;
- Complaints can be confidential or anonymous;
- Mediation services are available; and
- Where negotiation and mediation have not resolved the problem, the Complaints Resolution Committee will determine a course of action, which is binding on the service provider.

Reference: For more information refer to the Department's web site www.health.gov.au

KEY FINDINGS

24. Independent complaints mechanisms are an important element in service monitoring.
25. Complaints agencies need adequate resourcing and a range of legislative powers available to them if they are to complete the required tasks effectively.
26. Agencies should adopt a structured approach to facilitating systemic improvements through the review and analysis of patterns of complaints and effective approaches to addressing issues.

3.6 INCREASING PROFESSIONALISM

"The people who work in social care are called on to respond to some of the most demanding, often distressing and intractable human problems. Yet there are few public accolades for getting it right and virulent criticism for getting it wrong. Staff can feel embattled and undervalued, and their morale suffers." (UK Department of Health).

In Australia, as in other economically developed societies, community services (including aged care, child care, caring for people with a disability and people with a mental illness) has been one of the fastest growing employment sectors in recent years and is predicted to keep expanding.

Characteristics of the labour force in the community services sector includes:

- There is a low level of professional qualifications and training. For example, in Britain it is estimated that 80% of direct care providers working with vulnerable people have no recognised qualifications or training in this area (UK Department of Health, Modernising Social Services).

- There is a lack of national mechanisms to set and enforce standards of practice and conduct. Comparable sectors such as Health and Education have had such mechanisms for many years.
- The standards and suitability of some education and training in social care do not enjoy general confidence.
- The community service industry is dominated by female and part-time employees. Of the 98,897 persons working in the Australian nursing home industry at the end of June 1996, 70,542 were part-time females. Similarly, 94 per cent of total employees (36,135) in the child care industry were females, of which 57 per cent worked on a part time basis (Australian Bureau of Statistics, Community Services 1995-96).

Creating safer service environments requires careful screening, training and management of staff. In an extensive analysis of previous work Sobsey (1994) argues that this is best achieved through creating service systems that are supportive of both consumers and staff, attracting staff with the greatest potential and thoroughly screening staff to prevent potential abusers from entering caregiving environments.

The skills of direct care providers are also a significant factor in the incidence of abuse resulting from poor communication; stress resulting from inability to cope with work demands; failing to recognise client needs or evidence of abuse and aversive responses to challenging behaviour (see detailed discussion of staff skills and abuse in Sobsey, 1994; and Conway et al, 1995).

3.7 RECRUITMENT AND SCREENING

"Existing procedures make it easier to deny employment to an applicant whose past behaviours have been considered unsatisfactory or have given rise to concerns than to remove from a residential care setting a person already in employment." (Community Services Commission of NSW ,1996).

Employee probity screening is particularly important given the predatory nature of sexual abuse offenders and the vulnerability of people with a disability to this form of abuse (see Incidence in Section 3 and Building Individual Resilience in Section 4 of this review).

Issues identified in a number of Australian and international studies (Sobsey, 1994; Conway et al, 1995; Kennedy 1995) are consistent with the key findings of the Community Services Commission of NSW, 1996). In summary the major findings include:

- The sector offers a level of unsupervised access to and power over people with disabilities… sufficient to warrant being considered a special area of employment.
- It is not uncommon for people to be appointed to work with vulnerable clients without any screening or checking of their identity, criminal record, qualifications or work history.
- It is not uncommon for a worker to be dismissed or allowed to resign for improper conduct …without any record being made …and then to gain

employment in a similar setting without the new employer being aware of the circumstances.

- The needs of children and adults in residential care are not adequately protected in procedures for investigating complaints and dealing with employee behaviours, as these procedures focus on the industrial rights of the employee.
- Current screening and monitoring systems are unlikely to identify an offender who is seeking to avoid detection.
- The sector is diverse with a high reliance on casual and temporary employees, generally low rates of pay, limited career options, small recruitment pools and unmet supervision need. The work has little status within the broader community. As a result the sector does not attract staff with the necessary skills and integrity.
- Such criminal record checks as are currently carried out are of limited value.... due to constraints on the checking process.
- There is an unwillingness to share information within the sector due to concerns regarding security and use of the information in addition to confusion regarding the law of defamation and the rights and obligations of referees and employers when asked to comment on an employee.
- There is no structure to allow for the exchange of information (other than criminal convictions) about unsuitable employees/applicants between agencies.
- There is a lack of clear accessible policies and procedures for responding to allegations and expressions of concern about inappropriate staff behaviour.

The findings of the Community Services Commission (1996) relate to government and non-government services funded or approved through the NSW Department of Community Services, the NSW Department of Juvenile Justice and the NSW Ageing and Disability Department. However, the findings are consistent with common concerns raised in the literature regarding the failure of service systems to appropriately recruit and manage staff in services to vulnerable adults and children. The major recommendations of this report may be summarised as:

- Strategies are developed to address the effects of low pay, lack of status and career paths, inadequate training and the high proportion of casual workers.
- The development of clear and open guidelines for responding to allegations of improper conduct, the investigation of allegations and the recording of outcomes on agency files.
- All applicants recommended for employment in residential services should be required to submit to fingerprint checks, give consent for a range of inquiries to be made and provide declarations relating to their personal history.
- A community services probity unit should be established to access information not normally available to selection panels, to assess personal integrity and suitability.

- Each applicant should be required to obtain a probity clearance before being employed in the sector. The same should apply to volunteers, contractors, student placements etc.
- A central register should be kept of all persons (a) who have been prosecuted for sexual or personal violence offences; (b) who have been disciplined or dismissed for improper conduct; (c) who have resigned under circumstances where they could have been disciplined or dismissed for improper conduct. The register should be centrally maintained, available to all agencies working with people with disabilities, children and young people, and operate under strict privacy guidelines. Employers should be mandated to make notifications to the register and given appropriate notifier protection.
- The application of an "unacceptable risk" test to determine whether, in the best interest of a vulnerable client, the behaviours of an employee should deny him/her gaining or continuing employment in the sector.

The Commission recommends that the same considerations might apply for children in foster care. It may also be appropriate to consider the same systematic approaches to employee screening for service provided to other vulnerable populations including older people.

Currently all State and Territory CSDA jurisdictions encourage funded service providers to undertake criminal record probity checks on staff hired to work with people with a disability. However, Australian provisions for probity screening in adult services appear inadequate when measured against the recommendations of the literature. In the US, many states have developed more thorough systems of registries and criminal background checks to prevent perpetrators of abuse from gaining access to vulnerable adult populations, similar to those that have developed in children's service sectors (Mitchell and Bruchele-Ash 2000).

Example 22: Probity Screening Recommendations for Disability Services (NSW)

The findings of the Community Services Commission of NSW (1996) relate to government and non-government services funded or approved through the Department of Community Services the Department of Juvenile Justice and the Ageing and Disability Department. The findings are consistent with common concerns raised in the literature regarding the failure of service systems to appropriately recruit and manage staff in services to vulnerable adults and children. The major recommendations of this report may be summarised as:

- A community services probity unit should be established to access information not normally available to selection panels to assess personal integrity and suitability.
- Each applicant should be required to obtain a probity clearance before being employed in the sector. The same should apply to volunteers, contractors, student placements etc.
- A central register should be kept of all persons (a) who have been prosecuted for sexual or personal violence offences; (b) who have been disciplined or dismissed for improper conduct; (c) who have resigned under circumstances where they could have been disciplined or dismissed for improper conduct. The register should be centrally maintained available to all agencies working with people with disabilities children and young people and operate under strict privacy guidelines. Employers to be mandated to make notifications to the register and given appropriate notifier protection.
- The application of an "unacceptable risk" test to determine whether in the best interest of vulnerable client the behaviours of an employee should deny him/her gaining or continuing employment in the sector.

Reference: Community Services Commission of NSW (1996)

Example 23: Approaches to Child Protection Probity Screening (UK & USA)

USA CHILD PROTECTION PROBITY SCREENING

The USA National Child Protection Act, introduced in 1993 (and amended in the Crime Control Act 1994) encourages states to extend and improve the quality of their criminal history and child abuse records. The legislation provides for the following:

- A centralised data base.
- A requirement for all states to submit information to that central database.
- Minimum procedural safeguards for conducting criminal history record checks.

The legislation also authorises states to establish procedures that require organisations serving youth, the elderly, and individuals with disabilities to request a nationwide criminal history background check on prospective employees and volunteers. National guidelines are also provided to assist community-serving organisations in developing recruitment and screening policies and procedures.

Reference: Community Services Commission of NSW (1996)

UNITED KINGDOM CHILD PROTECTION PROBITY SCREENING

In the UK the Department of Health operates a consultancy service whereby local authorities, private and voluntary organisations providing children's services can check the suitability of those they propose to employ. The service:

- Records convictions against those who (at the time of conviction) are or were in child care work; it also notes the names of persons formerly in such work who have been dismissed or who have resigned in certain circumstances;
- At the request of employers, provides a check against these records in respect of individuals seeking work in a child care post;
- Alerts employers if the check is positive.

Reference: Community Services Commission of NSW (1996)

Improving the Recruitment Pool

While there are many highly skilled workers, there are also major difficulties in attracting and retaining suitable staff in the residential care area (Community Services Commission of NSW, 1996). Contributing factors to the devalued status of community service work include poor remuneration and working conditions; a high proportion of part-time, casuals positions and high turnover in staff; limited career paths; and low entry criteria, no pre-qualifications or training required.

Professional training for direct care workers has developed over recent years with the introduction of Vocational Education and Training (VET) qualifications in Disability Support and broader caring and community service work. However, employers have difficulty applying stringent integrity and skills criteria to staff recruitment when faced with small numbers of applicants and high staff turnover. The NSW Community Services Commission (1996) made the following recommendations for improving the recruitment pool for residential care services:

- The government, in consultation with stakeholders, should develop strategies to address staffing difficulties arising from the combined effects of low pay, lack of status and career paths the physical and emotional demands of the work and the high proportion of casuals in the residential care workforce.
- The government, in consultation with stakeholders, should develop strategies for raising the level of training and skills of people employed in the residential care sector, including an assessment of their understanding of the nature of the work, their skills and aptitude and their attitudes to clients in residential care.
- A number of other recommendations were made with regard to service providers improving recruitment and staff selection practices (eg clear job descriptions, advertising positions, probity screening etc.).

The Victorian Auditor-General (2000) recommends that common minimum competency standards be adopted for staff in both government and non-government services for people with a disability.

Only one Australian State (Queensland) has pre-entry qualification requirements for direct care workers employed in disability services. Some States/Territories have mandatory training requirements for direct care staff. However, no evaluation of these requirements has been identified; the enforcement and monitoring of these approaches, in addition to the adequacy of the training, may need consideration. The Commonwealth is introducing a Disability Service Standard related to staff competency that will provide a mechanism for ongoing quality improvement in this area through benchmarking.

KEY FINDINGS

27. Other human service sectors in Australia and overseas apply more stringent employment screening to people working with persons vulnerable to abuse. Options for strengthening probity screening include:
    - The introduction of mechanisms allow for the application of 'unacceptable risk' testing.
    - More readily accessible, nation-wide probity screening processes.
    - Cross-sector collaboration to develop common mechanisms for services provided to various vulnerable populations, such as older people, young people and people with mental illness.
28. Long term strategies to raise professionalism include raising pre-entry qualification and ongoing training requirements; improving wages and conditions; improving career paths; and raising the valued status of the work.

4. SAFER SERVICE ENVIRONMENTS

Many authors contend that it is at the level of service delivery that the primary protection measures can be taken to reduce the vulnerability of people with a disability to abuse and neglect. However, the Roeher Institute (1994) reports that there has been little research on the nature and effectiveness of protocols within individual service organisations.

Common factors in the abuse of people with a disability within service environment include:

Power imbalance between the person with a disability and the carer

One of the most significant factors predisposing people *with disabilities to abuse is the power differential that exists in service settings (The Roeher Institute 1994, Conway 1994, Sobsey 1994).*

Inadequate protection of human rights

The limited capacity of consumers to protect and promote their own interests and limited or ineffective safeguards for protecting the rights of individuals. Arrangements for providing and monitoring services to vulnerable populations, and the subsequent quality of those services, including poor policies and practices relating to prevention and responses to abuse, contribute to creating environments tolerant to abuse occurring (Sobsey, 1994; Conway 1995).

Abuse relationships within services

Poorly skilled staff and poor working conditions can lead to situations of staff resorting to abuse to control or manage people with a disability in service settings. Poor screening and management of services can provide opportunities for offenders to perpetuate abuse in service settings (Community Services Commission of NSW, 1996).

Social isolation

Isolation leads to people with disabilities having few powerful contacts they can trust and no one with whom they can disclose any instances of abuse, increasing dependency on caregivers for support and advocacy and making the individual more vulnerable to sexual assault and emotional abuse (Kennedy & Co 1997; The Roeher Institute 1994; Audit Office of NSW and Community Services Commission of NSW, 1997; Sobsey 1994; Chenoweth, 1995; Conway et al, 1996).

Organisational features in residential services that contribute to abuse appear to be common across populations and sectors including services for older people, people with mental illness and institution facilities such as prisons.
Features include:

- Failure to assess risk and create safer environments.
- Inadequate service management and policies/procedures to guide abuse prevention, identification and appropriate response.
- Inadequate supervision of staff, staff 'burnout'.
- Poor staff skills, lack of access to training; and inadequate or aversive approaches to behaviour management.

- Complex client needs and high staff turnover.
- Overcrowding; poor relationships between consumers due to people having little choice who they live or work with.
- Inadequate personal planning that prevents people from leaving service environments and being connected with broader social networks.

(Compiled from: Glendenning, 1999; Community Services Commission of NSW and Intellectual Disability Rights Service, 2001; Griffin & Aitkin, 1999; Saveman, et al, 1999).

Within any types of service setting a comprehensive approach to abuse prevention may contain a number of elements including:

4.1 ORGANISATION CHANGE AND CULTURE

4.2 TRAINING AND MANAGING SUPPORT WORKERS.

4.3 RISK ASSESSMENT.

4.4 POLICIES, PROCEDURES AND CODES.

4.5 BEHAVIOUR INTERVENTION GUIDELINES.

4.1 ORGANISATION CHANGE AND CULTURE

Previous work examining the incidence of abuse within the context of service delivery organisations, have identified the culture within the organisation and the environment in which services are provided, as a significant determinant in the likelihood of abuse occurring (see for example: Sobsey, 1994). Preventing abuse within the service setting will often require a change or process of ongoing improvement in workplace culture.

There is a large and increasing body of literature that addresses change, culture and learning in organisations and workplaces. The literature on organisational change has been particularly prolific in the second half of the twentieth century and represents many branches and perspectives.

Within the broader organisational change literature, a growing number of writers including Argyris and Schon (1978), Dunphy and Dick (1981), Kanter (1983), Senge (1990), Pedler, Burgoyne and Boydell (1991), Limerick and Cunnington (1993), and Garrick (1998) have examined and theorised about innovative practices and structures in organisations. They have identified and analysed underlying characteristics and behaviours including systems thinking, networking, flatter and flexible management structures, teamwork, collaboration, changed mindsets, empowerment and learning environments.

Following a similar course, but within the human services context, authors such as the MSTU (1993) and Kempin (1994, 1999) have also addressed the variety of factors and practices influencing organisational change, culture and learning. For example, the MSTU (ibid.) considered successful management practices in a community management context in Victoria, describing a number of different

types of organisation driven by the largely common values of participation, empowerment and equity. Themes of flexibility and responsiveness are supported as important common factors enabling agencies to adapt to change within the parameters of their philosophies and purposes.

Commentators discussing these approaches call for new forms of organisation and emphasise the human factors of change and success. They support the development of values and cultures that draw on the human potential of the workforce and encourage questioning and innovation by workers, and different forms of interaction, and emphasise the need for continuous learning and improvement. Most commentators point out that if learning and improvement are to occur broadly and continuously in organisations, a range of complementary organisational values, behaviours, attitudes, structures and processes need to be present to support and encourage learning, improvement and change. In line with this, and with a focus highly relevant to human service organisations, authors such as Dick and Dalmau (1991) and Kempin (1994, 1999) identify and discuss strategies and approaches to changing culture in order to support sustainable change in organisations.

Many authors acknowledge the central role of culture generally, and learning culture in particular, on organisational change and development. Schein (1992) describes culture as a pattern of basic assumptions that are learned by a group as it solves problems, that work well enough to be considered valid, and are taught to new members as the correct way to perceive, think and feel in relation to those problems (p12). In effect, culture sets the boundaries of behaviour and attitudes in an organisation, and so addressing the broader cultural context is critical to success in achieving effective change and improvement.

4.2 TRAINING AND MANAGING SUPPORT WORKERS

"All staff must share the responsibility for preventing abuse." (Conway et al, 1995).

“It seems clear from most of the recent literature that the key to quality hinges largely on the nature of interpersonal relationships.” (Nolan, 1999).

Nolan (1999) is not arguing for the responsibility for quality care to be placed on professionals, on the contrary he advocates a holistic approach to quality in residential services (in the context of services provided to older people). Within this approach the need for valuing quality staff is recognised as an essential component. Nolan identifies evidence from a range of sources that valuing staff relies upon systemic factors in the service environment, including but not limited to:

- Basic and ongoing training in knowledge and skills for qualified and unqualified care providers.
- Developing and nurturing relationships between staff and residents.
- Linking training to a coherent staff development program, as staff who have been empowered by training need to be exposed to a work environment that promotes innovation and change. In its absence the likely consequence is

raised but dashed expectations resulting in increased frustration and disenchantment.

- Ensuring that staff themselves feel valued and supported through positive feedback from peers and managers and through recognition of the emotional impact on staff of close relationships with people in their care.

Research has identified the value of education and training of carers in preventing abuse against vulnerable populations across various service sectors (Daro & McCurdy, 1994; Griffin & Aitkin, 1999; Sobsey, 1994; Nolan, 1999).

There is some agreement in Australian work that mandatory staff training on implementing policies on the three aspects of abuse - recognition, reporting and assisting people who have been abused - should be covered as part of staff induction practices and completed prior to any client contact (Conway et al, 1995; National Child Protection Council, 1996; Kennedy & Co, 1997). In other human service sectors such as child care and aged care minimum staff training requirements apply.

Conway et al (1995) found that respondents trained in recognising abuse, reporting abuse and assisting a person who had been abused were significantly more likely to report a case of abuse. However, that study found that only 51% of staff (in residential services) reported receiving formal training in the recognition of abuse and 60% in the reporting of abuse. Only 41% received formal training in methods to assist an adult who had been abused. In the USA, Orelove et al (2000) reported that only 25% of sampled educators whose employers had a policy on reporting abuse had received any training on the policy within the past three years.

Tichon (1997) argues for increased training and multi-disciplinary collaboration to respond to family-based abuse.

The Audit Office of NSW and Ageing and Disability Department (2000) and Dyson & ACROD QLD (1999) suggest that where staff are working alone and without direct supervision, safeguards should be in place such as adequate guidance and vigilance in monitoring.

High staff turnover can be indicative of problems of abuse (Kennedy and Co 1997) and it is suggested that service management structures must have mechanisms in place to monitor and investigate areas with high staff turnover. The relationship between staff turnover and abuse is also supported in the literature regarding services for children and older people (Daro & McCurdy, 1994; Saveman et al, 1999). Explanations of the impact of staff turnover include:

- High turnover reduces relationships between caregivers and consumers.
- Inexperienced staff are more likely to be susceptible to feelings of inadequacy, stress or resentment.
- High turnover may indicate poor working conditions, including lack of resources, training, overburden and stress.

- Staff may be leaving because they find the service environment or practices unacceptable with regard to people with a disability but feel unable to effect change.

The high use of casual and temporary staff has been identified as creating conditions which allow an opportunity for abuse by those who are so inclined and reducing the likelihood that staff will speak out on issues and practices that concern them (Community Services Commission of NSW, 1996).

There are no pre-entry qualification requirements for direct support staff and induction training varies considerably across jurisdictions. There is little evidence of CSDA jurisdictions requiring mandatory training in abuse identification, response or prevention. Such training is provided at the discretion of the service provider. It is appropriate that services manage their staff training activities, however, there has been no recent evaluation to assess the adequacy of direct care providers with regard to skills in abuse prevention and response.

In some jurisdictions training in duty of care or codes of conduct may be a requirement upon starting and behaviour intervention and communication may be longer-term minimum training requirements.

There is little evidence of systematic approaches to examine staff supervision and management issues or issues such as workload, stress and high staff turnover; each of which may be an indicator or contributing factor to abuse. This may be due in part to the diversity of the consumer population, the range of services types and the sophisticated approach that such research would require.

Example 24: Approaches to Staff Recruitment, Qualifications and Training (Aust)

STAFF TRAINING STANDARD (COMMONWEALTH)

The following draft Disability Service Standard will be incorporated into the new Quality Assurance System:

Standard 11: Each person employed to deliver services to the service recipient has relevant skills and competencies.

Key Performance Indicators

- The Service identifies the skills and competencies required of each staff member.
- The Service ensures that its staff has relevant skills and competencies.
- The Service ensures the provision of appropriate and relevant training and skills development for each staff member.

Reference: Department of Family and Community Services (survey response).

STAFF QUALIFICATION REQUIREMENTS (VICTORIA)

Staff working in disability services receive training in behaviour management based on the PART and IABA models. For documentation on PART, refer to Professional Assault and Response Training (PART), contact the Professional Group Facilitators Pty Ltd (Licenser), PO Box 513 Ringwood, Victoria 3134. For documentation on IABA refer to Institute of Applied Behaviour Analysis, LaVigna G. and Willis T., www.iaba.com

Reference: Department of Human Services, Victoria (survey response)

STAFF TRAINING RESOURCES (NEW SOUTH WALES)

The NSW Department of Ageing, Disability and Home Care will be creating a register of training resources on its web-site for human service and criminal justice personnel.

Reference: NSW Department of Ageing, Disability and Home Care (survey response).

MANDATORY CHILD PROTECTION TRAINING (CHILDREN'S SERVICES NSW)

All staff working in children's services in NSW must undertake mandatory training in child protection and are required to report any actual or suspected child abuse.

Reference: NSW Department of Ageing, Disability and Home Care (survey response).

6.4 RISK ASSESSMENT

Assessing risk within service environments and in relation to consumers is an area that has been identified by some authors as in need of further development. It has been suggested that the capacity of programs to assess risk might be improved by more sophisticated risk assessment tools (Goodrich, 1997; Baird, et al 1999; Tomison et al, 1997).

Predictive risk assessment tools rely on proven models of causation and influence. Such tools and models have been successfully developed in the child protection area, but not in the disability services sector. Functional models of abuse are now emerging that may allow further development of predictive tools.

Predictive tools are useful when assessing support needs and risk factors prior to an individual entering a services system or in preparation for a significant transition such as leaving school and starting work or entering a new residential service.

Within the context of the residential service setting Morath (1997 cited in Community Services Commission of NSW and Intellectual Disability Rights Service, 2001) proposes a model which aims to predict the occurrence of abuse, violence and neglect of people with a disability. The model identifies four main determinants that interact to either inhibit or promote abuse:

- Organisational factors such as governance, management practices and values base.
- Staff factors such as ratios, attitudes, knowledge and skills.
- Level of consumer sophistication and awareness.
- Extent of awareness of support organisations and related organisations.

Morath suggests that it is the interaction of one or more of these determinants that will impact on the increased or decreased risk of abuse. For example, where a service has poor management together with consumers who have low awareness of their rights, these factors can combine to increase the risk of abuse occurring.

In contrast a strongly performing determinant can serve to counteract the effect of a poorly performing determinant. For example, low consumer awareness and

a lack of capacity to respond to service practices can be countered by a high level of involvement of an advocate from a support organisation.

The strength of the service performance across the four determinants can have predictive value in determining risk. Morath suggests that this can be used to target prevention strategies.

Reactive risk assessment consists of the analysis of incidence data such as critical incidents or reported theft, and/or concerns or complaints. Analysis is used to examine patterns and thereby identify risk. This is a more common form of risk assessment in service settings. However, the degree to which services routinely undertake a review of data is unclear.

Despite the substantial literature on the causes and factors in abuse within residential services there have been few studies designed specifically to reduce or prevent abuse and even fewer evaluations of such programs (Community Services Commission of NSW and the Intellectual Disability Rights Service, 2001).

Risk assessment is not currently a consistent feature of the disability services sector, unless applied to people at risk of self-harm or harming others due to challenging behaviour. Broader approaches to examining risk within the context of the service and multiple factors have not been widely developed.

Example 25: Model of Risk Assessment in Residential Services (NSW)

A risk assessment model for residential services has been developed by Morath, 1997 that involves four determinants that may have an interactive effect on risk.

Organisational factors such as governance, management practices and values base.

- Staff factors such as ratios, attitudes, knowledge and skills.
- Level of consumer sophistication and awareness.
- Extent of awareness of support organisations and related organisations.

Morath suggests that it is the interaction of one or more of these determinants that will impact on the increased or decreased risk of abuse. For example, where a service has poor management together with consumers who have low awareness of their rights, these factors can combine to increase the risk of abuse occurring.

In contrast a strongly performing determinant can serve to counteract the effect of a poorly performing determinant. For example, low consumer awareness and a lack of capacity to respond to service practices can be countered by a high level of involvement of an advocate from a support organisation.

The strength of the service performance across the four determinants can have predictive value in determining risk. Morath suggests that this can be used to target prevention strategies.

This model requires further testing and development; it may be useful across other service types. Combined with the development of tools to measure individual risk, services may be better equipped to identify and respond to potential risk factors and their causes.

Reference: Morath (1997) *Systemic abuse and neglect: a model to predict its occurrence and evaluate preventions*; conference presentation.

KEY FINDINGS

29. There are few practical examples of implementation with regard to risk assessment in disability services. Examples that have been identified require further testing and development for broad application.
30. Further work is needed to develop more sophisticated of tools to measure individual risk.

4.3 POLICIES, PROCEDURES AND CODES

"The main responsibility for safeguards against abuse must lie within service design and management." (Craft, in Sobsey 1994).

The lack of clear and effective guidelines for service delivery staff to act on when confronted with abuse or potential abuse has been consistently identified as a significant factor in under-reporting and inadequate responses (Sobsey, 1994; The Roeher Institute, 1994, 1995b). Service policies and procedures should include:

- The need to include how abuse can be recognised, how abuse is to be reported and how to assist the abused person.
- Policies need to be accessible and understood by all staff, families and support personnel, including volunteers.
- The need to include neglect and unintentional neglect as types of abuse.
- Decisive disciplinary action for failure of staff to report abuse/cover up.
- Requirements for induction and in-service training in the policies and procedures.
- There need to be clear guidelines for how to deal with allegations of misconduct or inappropriate behaviour when a staff member is suspected to be a perpetrator of abuse.

  (Adapted from Sobsey, 1994; Kennedy & Co., 1997; Community Services Commission of NSW, 1996).

Kennedy (1997) developed specific guidelines for responding to consumer-to-consumer assault in response to the recognition that service delivery staff often fail to respond appropriately to incidents of this nature (An outline of the guidelines is provided in Appendix 5). When the offender is a consumer, staff are less likely to report the incident, to treat the person's actions as challenging behaviour rather than assault and to fail to take adequate care to protect the victim.

People with learning disabilities and people who live in residential service settings are particularly vulnerable to sexual abuse (Sobsey, 1994; Wilson; 1990). Various studies have recommended clear guidelines with respect to sexual activity within residential service settings (The Roeher Institute, 1995a).

There are some types of services provided for adults where the relationship of trust is so strong that no sexual activity is permitted between the person in the position of trust and the person he is caring for. The obvious example is doctors and patients where this is a matter of professional ethics.

Outside such clearly defined and recognised categories, the position may be more complex as adults over 18 should be seen as fully competent and able to make their own decisions whatever their age or any disability they may have. Nevertheless there are some services which can be identified where the relationship is clearly one based on authority and trust and the potential for exploitation is so strong that any sexual relationship would be unacceptable while the relationship continues.

Several State and Territory CSDA jurisdictions have developed policy and procedure guidelines to assist services to develop appropriate management tools for responding and reporting abuse. NSW is currently developing a comprehensive policy and guidelines for abuse prevention that will be trailed and evaluated through pilot testing and staged implementation.

Example 26: Policy Development, Abuse Prevention in Disability Service Standards (Aust.)

The Ageing and Disability Department in NSW is developing a policy and guidelines on preventing and responding to abuse and assault in disability services, to provide a framework for:

- The prevention of abuse and assault and to minimise the severity of incidents.
- Appropriate, timely and coordinated response by mainstream and specialist disability agencies.

Follow-up and evaluation (to ensure that response plans are implemented and to inform future practice).

Reference: Department of Ageing, Disability and Home Care, NSW (survey response).

In the Australian Aged Care sector the Code of Conduct and Ethical Practice Working Group has developed a draft Code of Conduct and Ethical Practice to assist partners In the aged care sector to work in a professional and ethical manner and to raise community confidence in the aged care industry.

Reference: Commonwealth of Australia (2000*) Draft Aged Care Sector Code of Conduct and Ethical Practice for Commonwealth Residential and Community Aged Care Services provided under the Aged Care Act 1997*, Department of Health and Aged Care, available from: www.health.gov.au/acc

Example 27: Guidance for Codes of Conduct on Sexual Activity (UK)

The Booklet Caring for young people and the vulnerable? Guidance for preventing abuse of trust; is produced by the Home Office Northern Ireland Office the National Assembly for Wales, Department of Health and Department for Education and Employment (UK). The UK Government provides this guidance to service provider it contains model principles and content requirements for codes of conduct for sexual activity within relationships of trust. This guidance has not statutory enforcement.

An extract from the guidance is provided in Appendix 3, it contains guidelines for the development of a code related to sexual conduct. Key features include:

- A clear policy statement on the paramount need to safeguard and promote the welfare of young people/vulnerable adults.
- An explanation of the relationship between the Code on abuse of trust and policies and procedures for safeguarding young people and vulnerable adults more widely from other abuse.
- An explanation of the circumstances in which a relationship of trust will arise and the responsibility that arises from that relationship and a definition of those to be protected by the Code.
- A clear statement that any behaviour which might allow a sexual relationship to develop between the person in a position of trust and the individual or individuals in their care should be avoided;
- A clear supporting explanation of what behaviour is or is not acceptable
- A clear statement that all those in the organisation have a duty to raise concerns (without prejudice)
- A clear statement that the principles apply irrespective of sexual orientation:
- The detailed procedures to be put in place; how to ensure abuse of trust is identified if it occurs;
- Sanctions for abuse of trust.

Reference: UK Home Office, *Caring for young people and the vulnerable? Guidance for preventing abuse of trust*; produced by the Home Office, Northern Ireland Office, the National Assembly for Wales, Department of Health, and Department for Education and Employment. Available from: http://www.homeoffice.gov.uk/cpd/sou/young.htm

KEY FINDINGS

31. Disability programs across Australian jurisdictions have developed policies and procedures for preventing and responding to abuse. There is a lack of information available pertaining to the evaluation of their effectiveness.

4.4 BEHAVIOUR INTERVENTION GUIDELINES

Some people with a disability can develop difficult or challenging behaviour, usually as a result of poor environment, life experiences, social skills, communication, or mistreatment. The presence of challenging behaviour can serve to increase the likelihood of either:

- The individual becoming a victim of abuse, through the reactions of others to the behaviour, or unaddressed self harm; or
- The individual becoming abusive towards others. *It is important to remember not all challenging behaviour involves abusive or violent action*.

The early identification and appropriate response to challenging behaviour or its precursors such as communication difficulties, signs of frustration or dissatisfaction, poor self-esteem, is important. It is therefore an effective intervention approach to preventing the development of behaviour that can lead to violence against other people. Significant work has been undertaken within the crime prevention field to identify early intervention pathways to preventing the development of criminal or violent behaviour (National Crime Prevention, 1999).

"Much scientifically persuasive international evidence has emerged over recent years that interventions early in life can have long term impacts on crime and other social problems. Overseas research also indicates the cost effectiveness of early intervention strategies when compared to the long term costs of crime and the criminal justice response." (National Crime Prevention, 1999).

Byrnes (1997 cited in Community Services Commission of NSW and Intellectual Disability Rights Service, 2000) reported that resident-to-resident violence is generally the culmination of previous challenging behaviour that had not been adequately addressed.

A developmental approach to crime prevention would focus on identifying and addressing challenging behaviour at an early stage, to prevent aggression escalating (Community Services Commission of NSW and Intellectual Disability Rights Service, 2000). This can be particularly important with regard to sexually aggressive behaviour as sexual assault is likely to be repeated.

There is a need to ensure that behaviour that presents significant obstacles to learning or which present potential danger to themselves or others, must receive appropriate behavioural intervention and support. It is equally important that this intervention does not involve strategies such as seclusion, restraint, medication or other forms of coercion unless it is lawfully defensible in order to prevent imminent and significant damage to the person themselves or other people (Community Services Commission of NSW, 1995b). Where it is foreseen that such measures may be necessary, these practices should be subject to authorisation, monitoring and review.

Within residential services appropriate behaviour intervention can prevent other consumers being subject to abuse or violence as a result of challenging

behaviour. However, there is a history of the use of excessively harsh or inappropriate behaviour management strategies and practices in services for people with a disability (Sobsey, 1994; Cootes et al, 1995; Community Services Commission of NSW, 1995a and 1995b).

There has also been a failure to identify and address systemic causes of challenging behaviours. Examples of systemic causes that are frequently not addressed include:

- incompatibility among residents;
- inappropriate staff expertise and values;
- lack of appropriate means of communication;
- lack of attention and one-to-one interaction between residents; and
- boredom and frustration arising from a lack of activities, external contacts and support services (Audit Office of NSW and Ageing and Disability Department, 2000).

There is a need to protect consumers from unacceptable practices such as physical or verbal abuse, punishment, sensory deprivation, restriction, harsh treatment and assault. Such practices are often identified as 'Prohibited' while some such as physical restraint may be used on a 'Restricted' basis under certain conditions.

Example 28: The Thanbarran Early Intervention Project, (ACT)

In 1999 staff at the ACT South Region of Disability Program broke away from the traditional model of supported accommodation. Their referrals from various areas were predominantly young men (15-20yrs) many with mild intellectual disabilities some had mental health issues; often they came from disadvantaged backgrounds and many had been in trouble with the law. Most of these young men had low self-esteem difficulty initiating or maintaining relationships and poor socialisation skills. The Thanbarren project provided accommodation and a Personal Empowerment Program (PEP) that provides a mechanism to use experiences to build self-esteem. A parallel program called the Skill Enhancement Group now provides pre-pre-training to gain skills for looking for work. The Thanbarren project now gets at least four referrals a week and interest from the courts.

Reference: ACT Department of Health, Housing and Community Care (survey response).

Example 29: The Montreal Prevention Project (Canada)

The Montreal Prevention Project targeted boys who were identified by preschool teachers as being disruptive. The project aimed to reduce disruptive behaviour of the young boys to achieve long-term improvement in their social and academic competence.

The program involved two years of intervention when the boys were aged 7, until they were about 9 years old. Intervention was aimed at teaching social skills and coping strategies for the boys. Training covered topics such as 'how to make contact' and 'how to help' as well as coping topics such as 'how to react to teasing' and 'what to do when I'm angry'. Methods of training included small group discussions, role-playing, coaching and rewards. At the same time, parents were trained to enable them to effectively monitor their child's behaviour, use discipline effectively and provide rewards for prosocial behaviour.

Follow-up on outcomes was conducted at completion of the program, and annually for the subsequent two years. Evaluations showed that boys who had participated in the program were significantly less likely to engage in bullying and fighting (both self-reported and teacher rated measures) and less likely to be involved in other delinquent behaviour (theft, burglary or alcohol abuse).

Reference: National Crime Prevention (1999*) Pathways to prevention: developmental and early intervention approaches to crime in Australia, p154.*

Additional consideration may need to be given to the use of psychotropic medication in behaviour management, as with physical restraint this can be a form of illegal restraint when it is overused, unnecessary, unprescribed or unauthorised. However, it also has a legitimate place in therapeutic approaches to supporting some people with a mental illness or intellectual disability.

Systemic problems with the prescribing, administration and reviewing of psychotropic medication in nursing homes led to a significant review of the problem in NSW. An initiative to reduce the use of medication in nursing homes led to the development of a Best Practice Model for use of Psychotropic Medication in Nursing Homes (NSW Health, 1997). This model is described in Appendix 6.

Key principles contained in the model include:

- Disturbed behaviour is not an individual phenomenon.
- The purpose of guidelines should be to assist doctors prescribing and nurses administering psychotropic medication to optimise the use of the medications.
- Comprehensive assessment may reveal the trigger or cause of the behavioural disturbance. A whole range of interventions can be used…. to ameliorate disturbing behaviours, or even prevent such behaviours developing.
- Special training in behavioural therapy might be necessary to equip formal and informal carers of residents presenting challenging behaviours.
- Behavioural and environmental manipulation is to be preferred to medications or physical restraints.

- All interventions, both pharmacological and non-pharmacological, should be evaluated and evidence of benefit documented.

The Best Practice model seeks to address a number of issues regarding the role of the General Practitioner in the prescription of medication. These include the need to resource General Practitioners to collaborate in multi-disciplinary teams in order to take a holistic approach to behaviour intervention; there is also a recommendation that the prescription of psychotropic medication be subject to peer review.

Example 30: Protection for People Receiving Behaviour Intervention Support (VIC)

The Victorian *Intellectually Disabled Persons Services Act* outlines provisions for the use of restraint and seclusion as behaviour intervention practices. The legislation is supported by guidelines for regional workers to assist implementation of legislation,which are to be reviewed as a result of consultation. The Restraint and Seclusion Policy is currently being updated (to be released January 2001). The use of restraint and seclusion must be approved by an Authorised Officer of the Department of Human Services and must be reported to the Intellectual Disability Review Panel which reports annually to Parliament. Data collection systems are being updated to better track the use of the interventions.

Reference: Department of Human Services, Victoria (survey response).

Example 31: Aged Care Restraint Policy (Aust.)

Extracts from the sample policy for the use of restraint in Crowley Care Centre, a residential aged care facility, described in an Aged Care journal (see reference below).

- Definition of 'restraint' includes both physical and chemical restraint, as well as direct and subtle forms of restraint such as leaving people immobile due to meal trays or use of water chairs.
- A thorough, documented individual assessment is required including assessment of health status, medication being taken and their effect, the nature of the issue, alternative strategies, the resident's response. A medical officer must give authorisation.
- The resident's family is to be notified and consulted regarding the intention to restrain; they should also be kept informed of the incidence of restraint application and its effects; residents and/or their representatives should complete the relevant section of the authorisation form.
- The Centre Manager is to be informed of all episodes of restraint and impact of the restraint.
- Authorisation to use restraint is valid for six weeks only after which the practice must be referred.
- There are maximum periods for which a physical restraint can be applied and observations must be made and documented at short intervals (eg. 10 minutes).

Reference: Price G., (2000) Restraint Considerations: Crowley Care Centre Restraint Policy, *Geriaction,* Vol 18 (3) September

Australian jurisdictions have adopted various approaches to assist services to provide appropriate supports to people with challenging behaviour. The table below summarises the common approaches.

Figure 12: Current Mechanisms to Support Appropriate Behaviour Intervention.

INTENT	MECHANISM
Eliminate or restrict aversive behaviour intervention practices and protect consumer rights.	Legislation restricts the use of specific interventions to be used only with guardian authorisation. Policies and guidelines or manuals define or describe 'prohibited' and/or 'restricted' practices. The use of restricted practices may be monitored by authorised officers and reported to an independent body in order to oversee both individual cases and overall use of these practices.
Encourage the appropriate support and positive behaviour intervention for those consumers who demonstrate challenging behaviour.	Resource manuals/guidelines identify positive approaches to behaviour management. Provide access to specialist advice through teams or individuals available to work with consumers or service providers. Provide additional funds for supporting consumers with specific needs requiring intensive assistance.
Provide or encourage access to professional development.	Make staff training available and/or encourage staff participation. Provide resources (eg books, videos, brochures) to assist services to train staff.

From the review of literature and practices across jurisdictions and other human service sectors the following principles, might be applied to safeguarding consumers with regard to restraint and seclusion:

- There should be statutory authorisation for the use of restraint and seclusion in individual cases and independent monitoring and review of these practices across the jurisdiction.
- That a person independent of the service provider, and who is required to act in the best interests of the individual client, is responsible for reviewing and consenting to proposals to use restraint or seclusion.
- The safeguards should be broadly applied and not limited to people living in CSDA-funded residential services.
- The statutory definitions, and accompanying approval and reporting mechanisms, for "seclusion" and "restraint" should cover all forms of these restrictive practices, such as physical restraint or when a person has been placed in a room or other area in such a way that they are unable to leave.
- There should be time limits to the amount of time that a person can be placed in seclusion, and the conditions under which seclusion can be used are much broader than those permissible for the use of restraint.

Example 32: Handbook for Positive Behaviour Management (NSW)

The NSW Community Services Commission (1995) highlighted a number of restrictive practices that have been used within large residential facilities for people with developmental disabilities. The Commission's report created the impetus for the NSW Government to produce a comprehensive handbook *The Positive Approach to Challenging Behaviour*. This provides clear guidance to services in the development of their policies and procedures on challenging behaviour, including a clear articulation of what practices are prohibited and what practices are restricted and require the granting of a Guardianship order to enable their use and proper control.

Reference: The Positive Approach to Challenging Behaviour, published by the NSW Department of Ageing, Disability and Home Care is, available through: www.add.nsw.gov.au

KEY FINDINGS

32. Good practice in behaviour management can prevent consumer-to-consumer abuse by addressing systemic causes such as compatibility, communication, lack of stimulating activity, individual autonomy, appropriate supports and staff responses.
33. Strategies employed within Disability Programs to protect consumers from overly restrictive, harsh or abusive behaviour management practices, include:
    - Legislation restricts the use of specific interventions to be used only with guardian authorisation.
    - Policies and guidelines or manuals define or describe 'prohibited' and/or 'restricted' practices.
    - The use of restricted practices is monitored by authorised officers and reported to an independent body in order to oversee both individual cases and overall use of these practices.

5. RESPONDING TO ABUSE OR IDENTIFIED RISK

The literature consistently identified the following measures to ensure effective response to abuse (The Roeher Institute, 1994):

- Clear guidelines for recognition and reporting.
- Coordinated interagency responses to abuse.
- Affordable, accessible counselling and other supports for victims of abuse.
- The appropriate involvement of law enforcement personnel/agencies.
- Improved access to justice.

These needs are explored in more detail in the following sections:

5.1 RECOGNITION AND REPORTING

There is general agreement in the literature that support workers in disability services need training and information to recognise abuse against people with a disability.

In a recent US study on responses to children with disabilities who have been maltreated, Orelove et al (2000) found significant limitations in knowledge in how to recognise and respond to maltreatment of children with disabilities. Only 79% of sampled educators said that their employers have a policy on reporting abuse.

The absence of clear procedures and strong reinforcement by management has been identified as a factor that can lead to insufficient attention being given to indications of possible abuse (Victorian Auditor-General, 2000).

Directions for responding immediately and appropriately to incidents, allegations or suspicions of abuse need to be readily available and at-hand. Policies, procedures and resources for support workers often include a list of 'indicators' to prompt support workers to identify indications of abuse (see for example Appendix 4) and guidance for taking immediate action such as reporting to

senior management; contacting authorities; caring for victims and appropriate steps to protect them from further abuse.

Streamlining the process and reducing the complexity of reporting mechanisms and decision-making can improve response. Brown et al (1996) have developed a system of job aids called AIMS – alerting, investigating and managing – which outlines the steps which should be taken from the recording of an initial concern or allegation through the allocation of the case for investigation, the planning and conduct of the investigation, to case conferences and the design, implementation and review of a protection plan. Tools such as these can assist workers by providing guidance and streamlining documentation.

Focht-New (1997) has identified key areas of improvement to overcome historical barriers to the effective recognition, assessment and response to the abuse of people with developmental disabilities, including:

- The need for careful observation of individual wellbeing and behaviour to recognise indicators of abuse, such as increased self-neglect or aggressive behaviour, unexplained injury, or changes in psycho-social behaviour. This can be enhanced by professional training of caregivers and stable relationships between caregivers and consumers that contribute to understanding, communication and attachment.
- The need for creative communication and technology including facilitated communication, nonverbal communication etc.
- Skills of health providers and investigators in communicating with people with a disability and in using assessment tools developed for this population (such as the TRIADS checklist developed by Burgess, Hartman, and Kelley 1990). The TRIADS checklist evaluated types of abuse, the autonomic response of the individual abused, duration of abuse, and style of abuse. Resultant information is used to develop a plan of support.

There are many factors that impinge on the under-reporting of abuse, not least being the extent to which it is taken seriously. Barriers to reporting abuse have been identified by a number of authors:

On the part of the person with a disability themselves:

- Person doesn't know who to report to or person expects that they won't be believed or will be discredited in legal hearings because they have a disability.
- Person fears retribution or loss of services/supports.
- Person fails to recognise the difference between appropriate and inappropriate treatment; or has communication difficulties. In particular, if the person with a disability uses non-verbal communication or has a communication impairment, they may have difficulty in telling anyone of the abuse, and even if they can do so, the individual is not often believed.
- Person is accustomed to passivity and compliance.

On the part of others:

- Lack of training on how to identify the signs of abuse and neglect and in relation to reporting laws or lack of clear legal definitions of what constitutes reportable abuse/neglect.
- Feel uncomfortable infringing on the privacy of the family or the fear (especially by service providers) that reporting will harm family-professional relationships.
- Seen as pointless if there are no services and resources available to help the victim or fears that reporting will lead to further harm of the victim.
- Lack of confidence in the protective services system.
- Fear of repercussions if abuse not found to be present.

(Lists adapted from: Sobsey, 1994; Mitchell and Bruchele-Ash, 2000 Tharinger et al, 1990; Chenoweth, 1995 ; The Roeher Institute, 1994, 1995a)

Many crimes never come to the attention of the police. An Australian study found that 40% of crimes against people with mild or moderate mental retardation went unreported to the police, and 71% of crimes against people with more severe disability went unreported (Wilson and Brewer, 1992, cited in Sobsey, 1994). A study in Canada found that almost 75% of sexual abuse cases were not reported (Sobsey and Varnhagen, 1988). Barriers to bringing complaints to the police include:

- A perceived lack of credibility of women with disabilities acts as a barrier to reporting incidents of abuse to the police (Canadian Panel on Violence against Women, 1993 cited in The Roeher Institute, 1994).
- Because they have internal procedures in place for managing complaints, abusive incidents within disability services may not come to the attention of the police (The Roeher Institute, 1994).
- The police are currently playing the role of 'gatekeepers' to justice, by exercising discretion to screen cases from coming to the attention of the courts. In effect the police are in a position to prevent the court and legal system from perceiving the need for reform of the judicial system to ensure justice for those who are most vulnerable to victimisation (The Roeher Institute, 1994).

Mechanisms to increase the rate of reporting of abuse of people with disabilities need to be accompanied by mechanisms for investigation and provision of protective responses, if they are to be effective in preventing abuse.

KEY FINDINGS

34. Directions for how direct service delivery staff respond immediately and appropriately to incidents, allegations or suspicions of abuse need to be readily available and at-hand.
35. Training for support providers is required on how to identify the signs of abuse and neglect.

5.2 'VULNERABLE ADULT' PROTECTION

In other sectors of human services, a key systems response for abuse prevention is the existence of a protective intervention process, and requirements for mandatory reporting of suspected abuse or neglect of target populations. Protective intervention and some forms of mandatory reporting are most universally applied in relation to the abuse and neglect of children. Adult protective systems are described in the literature in relation to elder abuse and people with disabilities in a number of overseas jurisdictions.

Three major issues within protective systems that deserve particular attention are involuntary protection, mandatory reporting and protecting whistleblowers. Each of these is given some attention in this section.

Australian Jurisdictions

In Australia, a number of States have additional legislation specifically designed to protect the rights of people with disabilities using services, and that play a more direct role in preventing and responding to abuse of consumers of specialist services. Examples include the employment screening legislation in NSW, the Victorian Intellectually Disabled Persons Services Act 1986; and the NSW Community Services (Complaints, Review and Monitoring) Act, 1993. In addition, all States and Territories have generic legislation such as anti-discrimination (State and Commonwealth) and criminal codes, which are relevant to the way in which services are provided. The Crimes Act (reprint 1999) contains specific provisions to protect people with intellectual disability from sexual exploitation. It is illegal for a residential worker to have a sexual relationship with a resident.

The majority of States and Territories have specific legislation regarding guardianship for people who are found to be unable to make informed decisions, and require a substitute decision-maker. Guardians can typically be appointed for people who have a disability, mental illness or reduced capacity due to ageing or illness.

In the child protection arena, mandatory reporting of abuse is commonplace (Conway et al, 1995; Cootes, 1995). Since being first introduced in 1937, various States have gradually expanded the range of professions covered by mandatory reporting of child abuse (Australian Institute of Health and Welfare, 2000).

By 1999, all States and Territories, other than Western Australia, have legislated mandatory reporting of child abuse (WA has protocols for inter-agency referral, rather than legislation). However, there is little consistency in the professional groups subject to mandatory reporting, types of abuse covered by mandatory reporting, and the procedures for reporting.

There are some questions about whether increased reporting rates because of mandatory reporting is effective in producing a greater proportion of substantiated notifications. Mandatory reporting may also be limited where professionals are dissatisfied with the system of child protection and so may be reluctant to report suspicions of abuse (NSW Legislation Review Unit, 1996).

In the context of protecting children from abuse, mandatory reporting is one element of a broader child protection system that includes legislative provisions and operational structures for investigation, intervention, and alternative care and guardianship.

A number of States and Territories have developed mandatory procedures for reporting certain types of incidents involving consumers in disability services. In general, these reporting procedures are part of contractual arrangements between the funding body and the service provider, and do not form part of a broader protective intervention framework, as in the child protection area.

International Jurisdictions

The enactment of adult protection legislation in provinces of Canada, has been examined by Gordon & Tomita 1990 (cited in Health and Welfare Canada, 1993a). Examples of specific legislation have been examined by other authors, for example the legislated adult protection provisions in New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland (Roeher Institute, 1994). Adult protection legislation has both strengths and weaknesses. Gordon & Tomita identify that there is support for adult protection legislation because it clarifies the powers of intervention for health and social service workers; and because it outlines a set of procedures for initial and long-term case management.

Adult protection legislation has been criticised because:

- It resembles child protection statutes and is strongly paternalistic.
- The statutory definitions are imprecise because of a lack of agreement on what constitutes abuse and neglect.
- Intervention criteria are broad, and rest in part on the vague, stigmatising term of "mental infirmity".
- Older people may be ordered or removed from their homes.
- There is no statutory provision for sufficient support services to deal with cases.
- The area of institutional abuse and neglect is largely ignored.

A matter of debate in the adult protection literature is the issue of mandatory reporting. This may or may not be a feature of an adult protection framework.

Mandatory Reporting

Gordon & Tomita (1990) describe arguments against mandatory reporting of abuse against vulnerable adults, as follows:

- It is premature to demand reporting when definitions of what constitutes abuse and neglect are vague.
- The compulsion to report suspicious events creates a society in which people have to spy on each other, and erodes fundamental democratic ideals and principles.

- New investigative procedures and data banks containing personal information will be created, and inevitably misuse will occur.
- A compulsory response is required, and older adults may have unwanted or unnecessary "therapeutic" interventions thrust upon them. This limits an older person's right to self-determination and may encourage people to be labelled "abnormal" if they do not conform.
- Ethical dilemmas encountered by practitioners are amplified.
- Practitioner-client confidentiality is overridden, which may limit victims voluntarily seeking assistance.
- Valuable resources are consumed by "policing" families rather than providing preventative and support services to them.

Gordon & Tomita (1990) also identify arguments in favour of mandatory reporting:

- Intervention is facilitated at an early stage.
- Awareness of abuse and neglect is heightened.
- Potential abusers may be deterred if they know they will be reported.
- Immunity from prosecution is ensured for people who report and investigate suspected cases.

The authors conclude that voluntary reporting may address the concerns of those opposed to mandatory reporting, while satisfying those who argue in favour of some reporting system. There is evidence that voluntary reporting is as effective as mandatory reporting in ensuring that protection and assistance are provided for adults in need.

Some Canadian provincial statutes provide for the mandatory reporting of suspected abuse and neglect that occurs in non-institutional settings with penalties for those who fail to report. There is widespread agreement that mandatory reporting is necessary in institutional settings, but there is considerable disagreement on its appropriateness for non-institutional settings (Gordon & Tomita, 1990 cited in Health and Welfare Canada, 1993a).

Other examples of legislative arrangements for adult protection are available from the USA and more recently the UK. These include:

- The US Developmental Disabilities Assistance and Bill of Rights Act (1994 and Supplement 1998) mandates the creation of state protection and advocacy systems designed to protect persons with developmental disabilities from discrimination and abuse (Mitchell and Bruchele-Ash, 2000).
- California created the Elderly and Dependent Adult Abuse Reporting Law in 1983 to provide protection to adults whose dependency results from either age or disability (Baladerian 1991).
- Pennsylvania changed their voluntary reporting under The Older Adults Protective Services Act to mandatory in December 1997: “Any employee... who has knowledge that abuse has been or is being penetrated upon an older

adult (60 yrs+) is required to report the abuse, depending on the severity of the abuse."

- In the UK, the Care Standards Bill has been developed to provide better protection for individuals needing support and care. This is a national policy for the protection of vulnerable adults that requires the development of local multi-agency codes of practice to ensure a coordinated response to the issue of abuse.

One of the difficulties in such legislation is the definition of a 'vulnerable adult'. The broad definition referred to in the 1997 consultation paper "Who Decides?" (issued by the UK Lord Chancellor's Department) is a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."

This paper also provides a starting point for determining how serious or extensive abuse must be to justify intervention, building on the concept of 'significant harm' in the UK Children's Act. *"Harm should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development."*

When considering the appropriateness of intervention an assessment of seriousness of the following factors needs to be considered (UK Department of Health, No Secrets, 2000):

- The vulnerability of the individual.
- The nature and extent of the abuse.
- The length of time it has been occurring.
- The impact on the individual.
- The risk of repeated or increasingly serious acts involving this or other vulnerable adults.

The UK model proposes a multi-agency management committee for adult protection to determine policy, coordinate activity between agencies, facilitate joint training and monitor/review progress.

There is limited literature on the structure and effectiveness of protective intervention frameworks for adults. There have been no studies undertaken in the US to look at the specific provisions of state laws with regard to addressing the abuse and neglect of persons with disabilities, nor of their effectiveness in dealing with the problem (Mitchell and Bruchele-Ash 2000).

Involuntary Protection

The Adult Protective Services System (APS) in the majority of states in the USA has the ability to provide involuntary services. Involuntary services are interventions initiated by APS social workers, without the consent of the affected adult, for the purpose of safeguarding the vulnerable adult who is at risk of

abuse, neglect or exploitation (Duke, 1997). The services are involuntary because: (1) the recipient lacks the capacity to consent to receive the services; (2) there is no person authorised to consent on his/her behalf; and (3) intervention is ordered by the court of jurisdiction. Authority to intervene comes from a variety of sources including state statutes, administrative rules, policy and procedures and court orders (Duke, 1997).

The dilemma for APS social workers in cases of involuntary intervention is not in providing a service the adult does not want but rather in determining whether the adult is capable of choosing what he/she wants. An adult's right to choose danger over safety is undisputed. However, an adult who is unable to understand the options available to him/her and their probable consequences, who cannot comprehend the information that is relevant to the decision to be made, and who cannot understand how pertinent information applies to his/her circumstances, is not able to formulate an informed decision (Duke, 1997).

Concerns regarding the provision of involuntary protective services to adults are comparable to concerns regarding the appointment of guardians as substitute decision-makers; there is a risk that the wishes of the individual will not be appropriately recognised or respected.

Studies in the USA in 1993 (NAAPSA, 1993) and again in 1997 (Duke, 1997), have found that less than 10% of Adult Protective Services recipients receive services without their consent.

In those cases when services are provided without consent, they are typically situations that may be defined as an emergency. An emergency is described as an adult living in conditions that present a substantial risk of immediate physical harm and/or death without protective intervention. Medical treatment for a physical health problem is the most frequent service provided through legal intervention. Those States providing services involuntarily take steps to ensure the protection of rights including due process court protection such as the right to a jury trial, multi-disciplinary evaluations, and physician statements regarding capacity to decide.

Duke (1997) reports that the national study of involuntary protection services identified concern amongst social services, professionals, members of the medical profession and the general public, that involuntary services are not more readily available.

Typically there is a far greater outcry when APS does not intervene involuntarily in endangering situations at the urging of family, the public, and the medical community, than there is concern about unwarranted or inappropriate involuntary intervention (Duke, 1997).

Example 33: The Development Of 'Vulnerable Adult' Legislation (UK)

One of the difficulties in such legislation is the definition of a 'vulnerable adult'. The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper "Who decides?", issued by the UK Lord Chancellor's Department, is a person:

"...who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".

This paper also provides a starting point for determining how serious or extensive abuse must be to justify intervention, building on the concept of 'significant harm in the UK Children Act:

'Harm' should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development'.

When considering the appropriateness of intervention an assessment of seriousness in the following factors needs to be considered:

- The vulnerability of the individual;
- The nature and extent of the abuse;
- The length of time it has been occurring;
- The impact on the individual; and
- The risk of repeated or increasingly serious acts involving this or other vulnerable adults.

Reference: UK Lord Chancellor's Department (1997) *Who decides*.

Example 34: Adult Protective Services (USA)

Legislatures in all 50 states have passed some form of elder abuse prevention laws. Laws and definitions of terms vary considerably from one state to another, but all states have set up reporting systems. The 1992 Reauthorization of the Older Americans Act (OAA) established Title VII, Vulnerable Elder Rights Protection Activities. For the most part states have used state elder abuse prevention formula grant funds to support state-wide: service provider training; coordination among service systems and among service providers; technical assistance in the development of service system policies, procedures, and protocols; and public education. Generally, adult protective services (APS) agencies receive and investigate reports of suspected elder abuse.

The APS agency screens calls for potential seriousness. The agency keeps the information it receives confidential. If the agency decides the situation possibly violates state elder abuse laws, the agency assigns a caseworker to conduct an investigation (in cases of an emergency, usually within 24 hours). If the victim needs crisis intervention, services are available. If elder abuse is not substantiated, most APS agencies will work as necessary with other community agencies to obtain any social and health services that the older person needs.

The older person has the right to refuse services offered by APS. The APS agency provides services only if the older person agrees or has been declared incapacitated by the court and a guardian has been appointed. The APS agency only takes such action as a last resort.

State elder abuse prevention activities include:

- Central point of contact for complaints or concerns.
- Professional training, for example: workshops for adult protective services personnel and other professional groups, state-wide conferences open to all service providers with an interest in elder abuse, and development of training manuals, videos, and other materials.
- Coordination among state service systems and among service providers, eg creation of elder abuse hotlines for reporting, formation of state-wide coalitions and task forces, and creation of local multi-disciplinary teams, coalitions and task forces;
- Technical assistance, eg development of policy manuals and protocols that outline the proper or preferred procedures; and
- Public education, e.g. development of elder abuse prevention education campaigns for the public, including media public service announcements, posters, fliers, and videos.

Reference: For further information on Adult Protective Services in the USA refer to information and publications available from the National Centre for Elder Abuse (USA) www.elderabusecenter.org.

Protecting Whistleblowers

Common themes throughout the literature are that fear of retribution acts as a barrier to the reporting of abuse (Sobsey, 1994; Roeher Institute, 1994); and it is important to protect people who expose abuse or neglect in human services in order to create safer services (Saveman et al, 1999; Donaldson, 2000).

There appears to be little literature on the effectiveness of legislative provisions for protecting people reporting abuse with regard to people with a disability. Nonetheless, the principle of protecting those who provide disclosures and make reports appears widely accepted in other sectors. For example, a number of jurisdictions have introduced 'whistleblower legislation' that protects public sector

employees from retribution or reprisal if they report matters of corruption or maladministration. In the child protection area, legislation often includes a range of protections for people reporting the alleged abuse or neglect, including protection from defamation or other civil proceedings as a result of making the report, and protecting the identity of the person.

The provisions of whistleblower or child protection legislation may cover people reporting abuse of people with disabilities but are likely to only cover a limited number of situations where people are reporting abuse of people with disabilities. There have been a few legislative provisions developed specifically in response to this issue.

Example 35: Protecting Whisteleblowers (Aust.)

NEW SOUTH WALES: The Community Services (Complaints, Reviews and Monitoring) Act includes a clause that makes it an offence for any person to take or threaten to take 'detrimental action' against a person who has made a complaint, or provided information to the Commission. Reference: NSW Department of Ageing, Disability and Home Care (survey response).
QUEENSLAND: The Whistleblowers Protection Act 1994 allows 'anybody' to make a disclosure about a 'substantial and specific danger to the health or safety of a person with a disability' and be covered by the special protections for public interest disclosures. These protections include not being liable civilly, criminally or under an administrative process, for making a disclosure; and making unlawful any reprisals or detrimental action taken against a person making a public interest. Reference: Queensland Disability Services (survey response).

KEY FINDINGS

36. Elements of an adult protection system include defining 'vulnerable' and identifying conditions for intervention; guardianship; reporting – voluntary or mandatory; and protecting whistleblowers.

5.3 COORDINATED INTERAGENCY RESPONSE

"The legal service provider for the elderly must be connected to service providers, police officers, clergy, medical providers and others who are traditionally called upon to serve in the multidisciplinary approach to problem solving for the elderly. The solutions to elder abuse most often do not result from legal processes but from coordinated community response." (Levitt & O'Neil, 1997).

The need for inter-agency coordination when dealing with abuse notification and management has also been recognised in Australian and International jurisdictions and research reviews (The Roeher Institute, 1994; UK Department of Health, 2000; NSW Department of Community Services, 1996; Tapper et al, 1997; Levitt & O'Neil, 1997). Success factors include collaboration between agencies including social service providers, law enforcement, justice, victim support services and the effective function of inter-disciplinary teams.

The UK Department of Health has developed national guidance for implementing multi-agency policies and procedures to protect vulnerable adults from abuse

(UK Department of Health, No Secrets, 2000). This approach provides generic policies on abuse across vulnerable populations; implementation is coordinated at a local level through a lead agency. The national guidance identifies the following areas of performance for an effective inter-agency administrative framework to protect vulnerable adults:

- Identify role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of vulnerable adults.
- Establish mechanisms for developing policies and strategies for protecting vulnerable adults which should be formulated not only in consultation with all relevant agencies but also take account of the views of consumers, families and carer representatives.
- Develop procedures for identifying circumstances giving grounds for concern and directing referrals to a central point.
- Formulate guidance about the arrangements for managing adult protection, and dealing with complaints, grievance and professional and administrative malpractice.
- Implement equal opportunity policies and anti-discriminatory training with regard to issues of race, ethnicity, religion, gender, sexuality, age, disadvantage and disability.
- Balance the requirements of confidentiality with the consideration that it may be necessary to share information on a 'need-to-know basis'.
- Identify mechanisms for monitoring and reviewing the implementation of policy.

In other countries the coordination of a range of activities related to abuse prevention and responding to abuse have been based around a population or type of abuse. For example the USA Administration on Ageing coordinates activities nationally and through State based organisations, to address the abuse of older people.

Example 36: Elder Abuse Manual for Multi-disciplinary Teams (Canada)

In Canada in 1994 the Manitoba Seniors Directorate published a manual to assist professionals and service providers working with elder abuse. It provides practical advice on the introduction of the Multidisciplinary Team (MDT) approach to dealing with complex cases of abuse. This approach was first pioneered in the United States. Funding was made available in both countries for the formation of these teams. An MDT is a standing professional committee that can provide advice and guidance on appropriate strategies for intervention. Membership of the committee can be drawn from a variety of service areas for example:

- law enforcement
- health care
- legal/legislative
- mental health
- financial
- counsellors and advocates.

This model recognises the need to go beyond a single discipline agency or departmental response by

requiring the participation of a broader representation of the community.

Reference: Extract from Tichon (1998) *Abuse of Adults with an Intellectual Disability by Family Caregivers: the Need for Family-centred Intervention,* Australian Social Work Vol. 51 No. 1. Further information may be available by obtaining MDT Working Group on Elder Abuse and Manitoba Seniors Directorate (1994) Abuse of the Elderly: A Manual for the Development of Multi-disciplinary Teams Canada..

Example 37: Regional Violence Prevention Specialists (NSW)

Regional Violence Prevention Specialists are employed by, and accountable to, the Attorney General's Department. They are located throughout NSW in regional offices of the Department of Community Services, NSW Health or the NSW Police Service. The role of the specialists is to enhance linkages within and between Government and non-Government agencies; conduct community education and training; and develop prevention programs to reduce violence against women. Each specialist develops regional action plans reflecting regional priorities. They work with a Regional Reference Group to provide a means of addressing regional service delivery issues.

Reference: For more information about the NSW Strategy to Reduce Violence Against Women contact the Violence Against Women Specialist Unit, Crime Prevention Division, NSW Attorney General's Department, www.lawlink.nsw.gov.au

Example 38: Guidance to Develop Interagency Protocols (UK)

The Department of Health (UK) has issued a detailed guide for developing interagency protocols and generic policies on abuse across vulnerable populations; implementation is coordinated at a local level through a lead agency. The following areas of performance are identified for an effective inter-agency administrative framework to protect vulnerable adults:

- Identify role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of vulnerable adults.
- Establish mechanisms for developing policies and strategies for protecting vulnerable adults which should be formulated not only in collaboration and consultation with all relevant agencies but also take account of the views of service users, families and carer representatives.
- Develop procedures for identifying circumstances giving grounds for concern and directing referrals to a central point.
- Formulate guidance about the arrangements for managing adult protection, and dealing with complaints, grievance and professional and administrative malpractice.
- Implement equal opportunity policies and anti-discriminatory training with regard to issues of race, ethnicity, religion, gender, sexuality, age, disadvantage and disability.
- Balance the requirements of confidentiality with the consideration that, to protect vulnerable adults, it may be necessary to share information on a 'need-to-know basis'.
- Identify mechanisms for monitoring and reviewing the implementation and impact of policy.

Reference: UK Department of Health (2000a) *No Secrets: Guidance on Developing and Implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, UK Government Publication available from www.doh.gov.uk/scg/nosecrets.htm

KEY FINDINGS

37. Responding effectively to abuse requires coordinated interagency responses at the local area level, between agencies including but not limited to:

- Disability support services.
- Police and law enforcement agencies.
- Criminal justice personnel.
- Assault and crisis support agencies.
- Advocacy organisations.

5.4 SUPPORTING VICTIMS OF ABUSE

Research in Canada has consistently identified the lack of accessible services for victims of sexual assault who have a disability (The Roeher Institute, 1994). Emergency services, crisis centres, sexual assault centres and counselling programs that are accessible to women with a disability and have the appropriate experience to meet their needs are rare. These inadequacies are a direct result of funding shortages and a failure to account for the needs of women with a disability. Accessibility is not restricted to physical access, it includes the capacity to meet the needs of women with a diverse range of disability including sensory and developmental, who may have specific communication, support or understanding needs.

In the USA, a National Study of Women with Physical Disabilities, (Young et al,1997) found that inadequate access to services that assist women to escape domestic violence, was a primary factor in women with a physical disability remaining in abusive situations longer than women without a disability.

Womendez & Schneiderman (1991) provide advice for assisting women with a disability to escape from abuse based on the experiences in a women's shelter specifically designed for women with a disability. Without tailored facilities, escaping abuse can pose significant challenges for women with mobility difficulties, as shelters, courts, police stations etc are often not accessible. In acknowledgment of the high incidence of abuse among women with a disability, the provision of escape services specifically for or accessible to, women with physical and sensory disability should be a priority. Providing resources that assist women to plan an escape from abuse is also a desirable strategy. This includes practical advice related to transport, where to go, recruiting assistance from friends, and using restraining orders.

No evidence was found in the literature to demonstrate that the accessibility of such services in Australia has been systematically assessed. Anecdotal evidence tells us that access to crisis accommodation, including domestic violence centres, is notoriously inaccessible for women who require wheelchair access.

5.5 CRIMINAL JUSTICE ISSUES

A consistent issue in the literature is the poor access people with a disability have to the justice system. Barriers include the lack of physical and social access to the courts, rules of evidence, courtroom procedures that unfairly impinge on the rights of people with a disability and the lack of willingness to make reasonable accommodation to individual differences (The Roeher Institute, 1994; Sobsey, 1994).

Historically and internationally, the criminal justice system has been involved in relatively few cases of abuse of people with disabilities (Sobsey & Doe 1991). For example in NSW the Royal North Shore Hospital Sexual Assault Unit received approximately 50 allegations of sexual assault on people with an intellectual disability, in 1994, but only one person was charged with an offence (cited in NSW Law Reform Commission, 1996). This lack of involvement with the police and the criminal justice system in situations of abuse of people with a disability can be due to concerns such as:

- Belief that there is insufficient evidence for prosecution.
- View that the victim will not be capable of standing up to cross-examination.
- Concerns about the incarceration of people with an intellectual disability (where they are the perpetrator) (Kennedy & Co., 1997).

The difficulties faced by people with a disability in the criminal justice system forms a large, ongoing body of work that is beyond the scope of this project. Nonetheless, the review recognises the importance of the interface between the disability services sector and the criminal justice system from policy to practice in the area of abuse prevention.

Public policies on the abuse and neglect of persons with disabilities should include training to address discriminatory beliefs regarding the capacity of individuals to participate in the legal system and prevent the exclusion of persons with disabilities as witnesses, victims and offenders. (Mitchelle & Buchele-Ash, 2000). Sobsey (1994) suggests that criminal justice systems be persuaded to presume that all persons are competent to testify regardless of age or disability. Courts should provide reasonable accommodations and alternative court procedures to enable them to do so (Mitchelle & Buchele-Ash, 2000).

It has been recommended that advocates be made available to people with a disability and criminal justice personnel (including police) when a crime is being investigated or prosecuted (Refer also to the Criminal Justice Issues section later in this report). Advocates working with people in or in contact with the criminal justice system may need specific skills and resources.

5.6 PEOPLE WITH A DISABILITY AS OFFENDERS

There are conflicting views on the treatment of offenders with an intellectual disability in the criminal justice system, as demonstrated by the following extract from the NSW Law Reform report (1996) on People with an Intellectual Disability in the Criminal Justice System. A specific term of reference for the Commission

was whether and to what extent people with an intellectual disability should be diverted from the criminal justice system.

"A report of the Victorian Office of the Public Advocate argued that a decision by police not to charge because of a perception that persons with an intellectual disability are not 'responsible' for their actions is not in the best interests of the person (or the community) as the person is denied the right to an open examination of their guilt or innocence. The diversion away from the criminal justice system may also lead to additional social control or other adverse consequences. By contrast, the NSW Attorney General's Committee considered that discretion should be used prior to charging an offender with an intellectual disability, such as is already available to police when issuing cautions to children. While not advocating a lenient approach which would reinforce unacceptable behavior in such an offender the Committee considered that, in certain situations, having the police firmly impress on the offender that the behaviour is inappropriate may be beneficial." (Page 40).

The Law Reform Report proposed police when dealing with an offender who appears to have an intellectual disability adopt a Code of Practice. The Report also recommended 'a systematic and coordinated approach to people with an intellectual disability in the criminal justice system' as a priority, and identified the need for policies and services that recognise the disadvantage people with an intellectual disability face in the system. There was also recognition of the 'double disadvantage' many people with an intellectual disability experience due to compounding factors such as having limited financial resources; being juvenile, indigenous or female; or having a 'dual diagnoses' of mental illness.

The responsibility for reform in the criminal justice system lies outside of the CSDA jurisdictions. However, cross-sector approaches to developing support programs for people with a disability have significant potential benefit for reducing repeat offending and better supporting offenders.

Example 39: Criminal Justice Initiatives for People with a Disability (WA)

In August 1994 the corporate executive and the board of the Disability Services Commission approved the formation of a working party to promote access to justice for people with disabilities.

Membership of the working party comprised the Federal Court of Australia and the Magistrates Court of Western Australia; Policy and Legislative Directorate, Ministry of Justice; Office of the Public Advocate; Police Service of Western Australia; Mental Health Division, Health Department of Western Australia; Policy and Planning Directorate, Disability Services Commission; and State-wide Forensic Services.

Initiatives of the Working party included the Diversion Project, the Least Restrictive Viable Alternatives for Difficult Offenders Model, and the "Paired Resource." Profiles of these initiatives are provided below.

ENDING OFFENDING (WA)

Ending Offending is an education program for people with intellectual disabilities who have social, health, legal and addiction problems related to alcohol, developed by Associate Professor Steve Baldwin, Edith Cowan University and trailed in conjunction with the Disability Services Commission, Ministry of Justice (Juvenile Justice Division) and Alcohol and Drug Authority. The project achieved its objectives. A prototype has been developed and includes a manual, trainer's resources, bibliography and curriculum.

THE DIVERSION PROJECT (WA)

In 1996 the Fremantle Police Diversion Pilot Project was established as a joint initiative of the Disability Services Commission, the Ministry of Justice and the Police department with support from legal Aid Commission, Fremantle Council and Fremantle Mental Health Services. The Project was established to support diversion of people with decision-making disabilities who commit minor offences from the justice system into programs to minimise the risk of re-offending. The program was extended and independently evaluated in 1997, and in 1998 the evaluation report recommended the project be extended throughout the metropolitan area. The program moved to Rockingham Police district and was suspended in November 1999 and then terminated in February 2000 when the Police service withdrew support

The Access to Justice Working party continues a sub-committee to examine alternative models of diversion in Australia and elsewhere. The police have made a commitment to participate on this committee and have indicated a commitment to diversion in the broad sense, although with a perceived need for legislative reform before this could be implemented. The aim of the sub-committee is to develop alternative appropriate intervention programs aimed at reducing offending behaviour and increasing positive participation in community life. The issue of legislative change to support the new model shall be addressed.

LEAST RESTRICTIVE VIABLE ALTERNATIVES FOR DIFFICULT OFFENDERS MODEL (WA)

This model was developed to provide coordinated pre and post release options for people with disabilities serving interdeterminate sentences under the Criminal Law (Mentally Impaired Defendants) Act 1996, or who are constantly in and out of the prison system because of frequent, minor offences. Many of these people spend longer periods in prison than their nondisabled [sic] counterparts for similar offences, because of the lack of suitable programs to prepare them for release and the lack of suitable release plans to prepare them for their reintegration into the community. The model includes an assessment panel to support the Parole Board and the Mentally Impaired Defendants Review Board. An Implementation Committee is currently re-examining the model and the likely participants to decide whether the proposed models would be appropriate to the proposed target group and to secure funding.

THE "PAIRED RESOURCE" (WA)

The "paired resource" established two positions, one in the Ministry for Justice and the other in the Disability Services Commission, to work together to develop programs to cater for the needs of people with intellectual disability in the justice system. Projects included:

- A 'Structured Day Program' at Riverbank prison for prisoners with an intellectual disability;
- A prison pilot 'Life Skills' program;
- A modified sex offenders program for offenders with intellectual disabilities operating in both prison and community, and staffed jointly by Ministry and Commission staff;
- Support for the 'Frequent Offenders Program' an accommodation program managed by Outcare (a community agency) for people with intellectual disabilities who are frequently imprisoned for minor offences because of a lack of suitable accommodation;

The development of "Keep Cool," a modified anger management program for adolescents with intellectual disabilities, with a video being produced to support the program; and

The development of "Ending Offending" modified alcohol program for people with intellectual disabilities.

KEY FINDINGS

38. Improving access to justice for people with a disability is likely to improve reporting and responding to abuse, including increased support for victims and perpetrators who have a disability.
39. Strategies for improving access to justice include:
    - Addressing barriers to people with a disability giving evidence.
    - Training and cross-sector collaboration.
    - Providing advocacy support to people with a disability within the criminal justice system.
    - Diversion and intervention programs for people with a disability who are in contact with the criminal justice system.

5.7 COMMUNITY-BASED CRIME PREVENTION

Community or social crime prevention encompasses a broad approach to programs and other interventions that focus on changing the social conditions, patterns of behaviour or institutions that influence offending (Community Services Commission of NSW and Intellectual Disability Rights Service, 2001).

The fact that people with a disability are both perpetrators and victims of crimes within residential settings means that residents should be considered targets of crime prevention initiatives to minimise and reduce the likelihood of offending behaviour, as well as being considered the beneficiaries of crime prevention programs (Community Services Commission of NSW and Intellectual Disability Rights Service, 2001).

Geason and Wilson (1998) cited in Community Services Commission of NSW and Intellectual Disability Rights Service (2001) outline the stages involved in developing and effective crime prevention program:

1. Search for the local crime problems.
2. Select specific crime problem.
3. Analyse the crime problem selected.
4. Consider a range of possible measures.
5. Identify who will implement the measure.
6. Document the implementation process.
7. Monitor the changes in the crime situation over a long period.
8. Evaluate the program.

Adopting social crime prevention approaches requires a capacity to identify the crimes being committed in order to address causal factors. One of the barriers to developing approaches to address crime against people with a disability is the

lack of information available regarding crime due to under-reporting and under-recognition.

The capacity for Australian jurisdictions to identify the crime that people with a disability experience, may be enhanced by the identification of disability in community crime statistics. There are issues with regard to disclosure of disability; however, these are issues that have been addressed in other community data collection activities.

The USA government recognised the need to better identify victims of crime who have a disability, in order to raise community awareness and develop appropriate community responses. This resulted in the Crime Victims with Disabilities Act (USA) described in the practice example below.

Example 40: Crime Victims with Disabilities Awareness Act (USA)

Introduced in 1998, the Crime Victims with Disabilities legislation was designed to increase public awareness regarding developmentally disabled victims of crime, to collect data which measures the magnitude of the problem and to develop strategies to address the safety and justice needs particular to people with disabilities. The Act directs the Attorney General to:

- Conduct a study to increase knowledge and information about crimes against individuals with developmental disabilities that will be useful in developing new strategies to reduce the incidence of such crimes.
- Consider contracting with the Committee on Law and Justice of the National Academy of Sciences' National Research Council to provide research for such study.
- Report study results to specified congressional committees.
- Include, as part of each National Crime Victim's Survey, statistics relating to the nature of crimes against individuals with developmental disabilities and the specific characteristics of the victims of those crimes.

Reference: USA Department of Justice, for further information visit: http://www.usdoj.gov/

Community or regional approaches to social crime prevention focus on communities defined by geography or common interest/characteristic. This is of particular relevance to isolated communities, where isolation may be geographic, cultural or socio-economic. Community-based approaches may also be of significant value with regard to age groups – linking into strategies for preventing the abuse of children and young people.

Example 41: Preventing Crime and Focusing On Financial Exploitation (USA)

DISTRICT OF COLUMBIA, USA

Bank tellers can often spot signs of exploitation and dementia if they receive the proper training. D.C.'s Adult Abuse Prevention Committee sponsored two seminars on "Financial Abuse of the Elderly: Protecting Your Customers and the Bank." Nearly 100 people attended with three quarters from the banking community and the remainder from the senior service network. The seminars explained to bank staff the roles of Adult Protective Services the U.S. Attorney's office and others who can intervene in exploitative situations. The Seminars helped the network establish links with the District's major banks.

Reference: Selected from a list of crime prevention projects sponsored by the US government, for more information visit the US Department of Justice web site: www.usdoj.gov

Example 42: Community Based Sexual Abuse Response - Aboriginal Communities (Canada)

A joint project of the Government of Canada Solicitor General Canada and the Aboriginal Corrections Policy Unit culminated in a detailed manual titled Responding to Sexual Abuse: Developing a Community Based Sexual Abuse Response Team in Aboriginal Communities. The manual devotes considerable attention to understanding abuse within the context of the aboriginal community including acceptable and non-acceptable behaviours and the community dynamics that can impact on the incidence and nature of abuse. The manual then proposed a model of 'Community Wellness' that includes:

- Community-based strategies to create a cultural environment that discourages abuse focusing on the individual
- Family and community relationships.
- The manual provides resources for responding to abuse

Including interagency roles.

Within the response

- Attention is paid to the immediate and long-term needs of the victim
- the perpetrator
- other people involved and the community in general.

Much attention is given to the healing process which

- in small communities
- will necessarily involve all parties.

Reference: Government of Canada (1997) *Responding to Sexual Abuse: Developing a Community-Based Sexual Abuse Response Team in Aboriginal Communities,* available from: www.scg.gc.ca

The application of crime prevention within service settings has been examined in previous sections of this report. A broader approach is to examine the crime problems that people with a disability face across various settings including at home with family, in school, at work and in the wider community. An example of work in Australia would be the National Violence against Women Initiative that included particular research into violence against women with a disability.

A social crime prevention approach involves strong collaboration between agencies responsible for disability services and other government departments

such as those responsible for justice, law enforcement, young people and children. Significant partners in these approaches would include the National Crime Prevention Strategy and the National Centre for Criminology. It can also take the form of CSDA service providers and peak groups representing people with a disability becoming actively involved in local crime prevention strategies.

The development of Social Crime Prevention strategies within the CSDA service sector can build on and use the work undertaken by the National Crime Prevention Strategy, with regard to the development of crime prevention strategies and skilled practitioners across multiple disciplines, within local communities.

KEY FINDINGS

40. Social crime prevention is an approach to abuse prevention that may be applied in the CSDA in a number of ways. This approach requires the accurate identification of crime within a defined community or environment and cross-sector collaboration to develop and implement strategies for reducing crime incidence.

6. CHILDREN WITH DISABILITIES

"In general, natural families who are well embedded in their communities with strong attachments among all members of the family, provide relatively safe environments for people with disabilities. Simply keeping children in their natural families and avoiding placement in service alternatives is an excellent abuse prevention strategy. Unfortunately sometimes abuse can and does occur within the natural family itself." (Sobsey, 1994)

This Review has generally referred to the broad population of people with a disability, including children, adults and older people. However, there are specific considerations for children with a disability that warrant particular attention.

6.1 INCIDENCE

Few investigations of child abuse have identified children with a disability in their samples and there is no national Australian data collection. Overseas research that has identified children with a disability suggests that they are more likely to experience maltreatment with reported incidence ranging from 4 per cent to 70 per cent (Ammerman, 1990 cited in Tomison, 1997). For example:

- The US National Centre on Child Abuse and Neglect (1993) has estimated that children with disabilities encounter maltreatment at a rate 1.7 times greater than that for children without disabilities (Mitchell & Buchele-Ash, 2000).
- The Roeher Institute in Canada (1992) estimated that the sexual abuse of children with disabilities was 68% of girls and 30% of boys.
- A recent US study looking at maltreatment of children with disabilities (Orelove et al, 2000) found almost half (43%) of parent respondents and a majority (71%) of educator respondents indicated that they had suspected maltreatment of children with disabilities.

6.5 EXAMINING CAUSES

As with other children, the primary focus of studies into the abuse of children with a disability has typically focused on abuse within the family context. Tomison (1996) reviewed the literature relating to the maltreatment of children with a disability. He describes the following factors that have been suggested as contributing to a heightened risk for children with a disability include:

- Disruptions in the mother-child attachment as a result of the child having a disability, the parent may feel depressed, resentful, disinterested or unresponsive.
- Parental stress which may lead to frustration and an increased risk of physical abuse. Causes of stress may include: actual or perceived stigma; decreased personal time for the carer; extraordinary child demands; difficulties managing the child's behaviour; and general pessimism.

- Increased vulnerability of the child due to reduced capacity to defend themselves from assault or report incidents. Others may also have more difficulty recognising the abuse of a child with a disability.

6.6 PRIMARY PREVENTION

Several authors identify the need for changing social attitudes toward children with a disability as a primary prevention strategy (Tomison, 1996; National Child Protection Council, 1996). Promoting children with a disability as children first, having a disability second has been recommended (National Child Protection Council, 1996).

The role of schools in preventing the abuse of children with a disability includes:

- Educating all children to encourage their understanding and acceptance of disability,
- Teaching children self-protective behaviour or personal safety. Appropriate programs for children with a disability need further development for this to be effective (National Child Protection Council 1996). For example the 'Feel Safe' protective behaviours program developed in Western Australia (Tomison, 1996).

Muccigrosso (1991) has critiqued a number of examples of US resources for sex education programs for people with disabilities, primarily targeted at school level education, some of which may be usefully adapted to an Australian context. Some Australian CSDA jurisdictions report working with schools and education agencies to incorporate appropriate training programs into school education. A prescriptive approach to building self protective behaviour training into school education has been taken in California, where the Waters Child Abuse Prevention Training Act requires that abuse prevention programs be offered to all children at various grade levels including those with a disability (Baladerian 1991).

Sobsey (1994) identified the importance of reducing over compliance among people with a disability and suggests that this can be addressed by teaching parents, educators and care providers to ensure that compliance is not inadvertently taught to children and adults with a disability has long-term benefits with regard to individual resilience.

Ammerman (1997) also highlights the need for training for workers on dispute and conflict resolution and anger management when working with children who have a disability to prevent abuse that can result from poor coping skills. Further discussion on the need for appropriate behaviour management training is provided in following sections of this report.

6.7 FAMILY SUPPORTS

Hollingworth (1987, cited in Tomison, 1996) suggests that families with a child who has a disability should have access to the following services: extensive home-based support; child care; emergency or respite care; long-term care; appropriate educational services; financial support; parental counselling and

support for other children in the family. These supports need to be tailored according to the characteristics of the family and the child.

Example 43: Oregon Social Learning Centre Parent Training Programs (USA)

Parent training programs provided by the Oregon Social Learning Centre are based on the understanding that aggression in children can be fostered by failure of parents to use affective child-rearing and communication techniques. Programs targeted parents of pre-adolescent children who had been identified as anti-social, high rate social aggressors. {Programs focussed on the parent-child relationship and teaching parents to use positive, non-coercive methods of discipline and to deal consistently and decisively with anti-social behaviour. Specific strategies included teaching parents to monitor behaviour over long periods, clarify communication rules and expectations, clearly link rewards and punishment to behaviour and to negotiate acceptable standards of behaviour. Problem solving and conflict resolution skills were also addressed.

Reference: National Crime Prevention (1999) *Pathways to prevention: developmental and early intervention approaches to crime in Australia, p154.*p154-155.

Multi-disciplinary Approaches to Prevention

Effective interagency cooperation between disability services and child protection units is a key strategy to effectively prevent the abuse of children with a disability (National Child Protection Council, 1996). Expanding communication and collaboration with mental health services, education services, services for families and children as well as disability support services would improve the capacity of support providers to work effectively with families who have a child with a disability and who may be at risk of stress and potentially maltreatment (Tomison, 1996).

Orelove et al (2000) found that effective response to children with a disability who have suffered abuse requires good collaboration between multi-disciplinary professionals. Integral players including early educators, law enforcement personnel and counsellors; are more likely to collaborate effectively if they have attended training to bridge the knowledge gaps they have, these gaps need to be recognised and addressed.

"Equipping central players in the maltreatment area with disability-specific knowledge has historically been a missing element in the design of response systems to abuse and neglect of children with special needs" (Orelove et al, 2000).

Examples of multi-disciplinary approaches to the prevention and effective response to child abuse are provided below.

Example 44: Child Abuse Prevention Teams (USA)

The San Diego Regional Centre supports a SCAN (Suspected Child Abuse and Neglect) Team that meets bi-weekly. Team members include the special Regional Centre consultants nurses, psychologist sexuality educators and local experts hospital paediatrician and SCAN expert. This has tremendously strengthened identification skills and practices and helped many children and adults who might otherwise still be undiscovered or unreported victims of abuse

Reference: Baladerian, Nora J., (1991), Sexual Abuse of People with Developmental Disabilities, *Sexuality and Disability*, Vol. 9, Number 3, 1991.

6.8 SOCIETAL PREVENTION PROGRAMS

Societal and community approaches to preventing child abuse include early intervention projects, cross-sectoral collaboration and 'whole of community' initiatives (Tomison & Wise, 1999). These approaches have substantial value in addressing the structural social forces that can impact on families and contribute to the propensity for maltreatment.

The social crime prevention in schools has been documented in several recent papers. These programs typically focus on decreasing violence or crime within the school community and equipping children with the skills to prevent the development of offending behaviour.

These strategies, while promising with regard to long term outcomes on resiliency, there is a continued need for the capacity to intervene to reduce immediate risk. Tomison & Wise (1999) review a range of societal and community-based approaches and express support for .. *the adoption of a developmental prevention approach, where effective child abuse prevention requires acknowledgment of the inter-relationship between risk and resiliency, and solutions are developed to address the former and promote the latter.*

Example 45: The Children at Risk Program in Connecticut (USA)

The Children at Risk (CAR) program was designed to prevent delinquency and drug use among especially high-risk 11-15 year olds living in inner-city neighbourhoods in Bridgeport Connecticut. The central focus of the program is on the high-risk student

and this focus results in inclusion of the school social service agencies the police force and the juvenile justice system. Through a coordinated and intensive program the CAR model seeks to reduce risk factors for delinquency and drug use. Risk-factor requirements relate to school family or personal characteristics including behaviour problems a history of family violence or neglect or criminal behaviour. The CAR model incorporates eight core services with intensive case management. Case managers work closely with youths and their families through frequent contact at school and at home providing a range of supports and opportunities linking families to support services for specific needs such as substance abuse. Police patrol the school and build relationships with program participants, juvenile justice staff with participants involved in the criminal justice system.

This model requires effective interagency collaboration. Issues that effect the provision of comprehensive coordinated services are restrictions on information (confidentiality) and restrictions on providing services as well as professional differences in language and culture. Strategies to address these barriers included a release form signed by all professionals to allow collaborative sharing of information collocation meetings which led to cross-discipline understanding. Cooperation at all levels within participating agencies is required to ensure resource commitments are maintained.

Reference: Tapper et al (1997) *An Interagency Collaboration Strategy for Linking Schools with Social and Criminal Justice Services,* Social Work in Education, Vol 19 No. 3

6.9 RESEARCH AND ANALYSIS

In 1996 Tomison suggested that further research is required in Australia. He argues that national statistics should be collected on the abuse of children with a disability; to better define the problem. In addition predictive studies to establish causal factors hold potential benefit.

In a recent audit of child abuse prevention programs in Australia, Tomison and Poole (2000) from the Australian Institute of Family Studies identified 316 abuse prevention programs that target children affected by a physical or intellectual disability. These services were primarily family support programs, community education or child-focused programs (e.g. services involving substitute care). It is suggested that flexible, generalist prevention programs are able to cater to families in which a child or parent has a disability or mental illness. Further, particular models of service (e.g. respite care) are able to benefit a wide range of families with specific needs. Unlike culture-based populations including Aboriginal and Torres Strait Islander communities, the development of specifically targeted services is not considered to be the key to improving access to family supports for families that have a child with a disability. Access is more likely to improve if the overall availability of supports and prevention programs is increased and these supports are sufficiently flexible to cater to families with specific needs.

KEY FINDINGS

41. Strategies to address the abuse of children with a disability include:
    - Effective family supports;
    - The development and application of tailored self protection education programs in schools;
    - Collaboration to prevent over compliance being taught to children;
    - Multi-disciplinary training and collaboration with child protection response personnel to improve responses for children with a disability; and
42. A combination of risk reduction and health promotion in preventing child abuse has been recommended following a significant review of current and recent social or community based approaches.

SUMMARY OF CONCLUSIONS

UNDERSTANDING ABUSE

1. The identification and appropriate response to abuse is assisted by:
    - Consistent language used to describe abuse and neglect.
    - Descriptions of abuse that do not trivialise or decriminalise acts of abuse but rather provide a broader basis than criminal definitions for addressing systematic harm perpetrated on people with a disability.
    - Collaboration across human service sectors.
2. Vulnerability to various forms of abuse may be interconnected and prevention strategies may serve to reduce the likelihood of various forms of abuse.
3. The prevention of violence against people with disabilities is treated in various ways in the literature. Recommendations pertaining to prevention can be characterised as involving:
    - Systematic changes to eliminate the conditions that make it likely that people with disabilities will be subject to abuse.
    - Specific preventative measures within a variety of settings to make it less likely that people will be harmed or make them less vulnerable to abuse.
    - Measures to ensure effective response to abuse when it happens.
4. The capacity of services to reduce abuse and violence in the lives of people with a disability relies on ongoing development in the areas of identification, prevention strategies and appropriate responses.
5. Increased data collection and analysis with regard to the incidence of various forms of abuse across different service types may assist the development and evaluation of prevention strategies.
6. Ongoing research and analysis into the abuse of people with a disability is particularly needed in the following areas:
    - To identify the conditions that increase risk and the conditions that increase safety, across the diversity of service and community settings in which abuse occurs;
    - To investigate the interaction of disability and culture with regard to the incidence of abuse, including the experiences of indigenous people with a disability and those from diverse cultural backgrounds;
    - To ensure that increased knowledge results in improved practice, through continuous improvement mechanisms; and
    - To evaluate and he effectiveness of prevention strategies, including the application of emerging models in crime prevention and community harm minimisation within the disability services sector.

PRIMARY PREVENTION

7. The devolution of residential settings and the introduction of independent community-visiting programs are primary approaches to reducing social isolation within residential support services.

8. Primary prevention includes increasing the valued status of people with a disability and reducing community tolerance for abuse and neglect. Strategies include
   - Enhancing individual valued status through services, programs and individual supports.
   - Changing community attitudes through public education campaigns, harm minimisation programs, community leadership initiatives and school-based education.
9. Activities to change community attitudes toward disability and prevent abuse may be best targeted at a local level through service providers and peak groups representing people with a disability. These activities are unlikely to be a priority for service providers unless adequately resourced and supported at a National or State/Territory level through funding, providing materials and advice.
10. An examination of financial abuse within the CSDA sector in conjunction with strategies to address poverty, has potential benefit in addressing the financial dependence and lack of resources experienced by some people with a disability.
11. A range of advocacy services contribute to abuse prevention: those that assist individual people with disabilities and those that focus on issues that are important to many people with disabilities.
12. Service providers have a critical role in facilitating access to advocates and advocacy services. This role can be enhanced by being built into individual support planning, risk assessment and service performance monitoring.
13. Building individual resilience has been consistently identified as an important approach in preventing abuse. However, there has been limited evaluation of the effectiveness of specific strategies such as training programs developed in Australia.
14. Given the diversity of the population of people with a disability there may be economies in a national approach to sharing resources and curriculum and improving access to skilled training providers who can deliver training programs to specific groups (eg people with different types of disability). Such an approach would require coordination and maintenance, and would also need to be accessible to service providers, advocacy organisations and consumer groups.
15. A range of family and community based supports contribute to reducing stress in those families at risk of violence or abuse.
16. The development of approaches to identifying risk and appropriate family-centred intervention are necessary components in abuse prevention.

PREVENTING SYSTEMS ABUSE

17. Contemporary developments in the way services are provided to people with a disability have the potential to contribute to abuse prevention. For example:
   - Individual and portable funding that allows individuals to change services and change the supports that they receive, increasing independence and reducing the risk of abuse.
   - Defensible and individually focused funding or resource needs assessment.
   - Assessment and access mechanisms (that provide access to supports based on relative need and available resources) involve risk assessment including the potential risk of becoming either a victim of abuse or an offender.

- The development of performance data to inform planning and decision-making (which may include individual outcomes with regard to increased resilience to abuse, reduced risk of violence or harm).

18. Analysis of the literature on abuse prevention and quality improvement in the delivery of human services, has identified the following priorities for quality reform in Australian disability programs:

- Enhancing or tailoring Disability Service Standards to directly address the prevention of abuse and key factors within service environments that contribute to increased risk of abuse.
- Independent verification and monitoring of quality standards and performance, including more direct measures of output and performance.
- Independent consumer complaints and investigation mechanisms, with the authority and resources to fully investigate complaints of a serious or systemic nature, and to recommend sanctions where warranted.
- Supports such as professional training and resources such as policy guides, codes of conduct and research/development activity
- Higher penalties for breaches or evidence of unacceptable practice.
- Best practice strategies that include recognition of good practice and innovation and dissemination of examples and information.

19. Consumer empowerment is enhanced by high awareness of individual rights and skills in representing individual interests. Common strategies to achieve this include:

- Consumer training
- Staff training and service policies/procedures that uphold consumer rights;
- The use of a statement or charter of consumer rights as a resource for consumers, service providers and caregivers.

20. The importance of consumer participation in quality assurance processes is highlighted in the abuse prevention literature as contributing toward a culture of empowerment and responsiveness.
21. Better outcomes have been achieved in consumer participation, where government has provided independent support or training for consumer participation and made consumer representation a requirement in the quality assurance system.
22. Independent complaints mechanisms are an important element in service monitoring.
23. Complaints agencies need adequate resourcing and a range of legislative powers available to them if they are to complete the required tasks effectively.
24. Agencies should adopt a structured approach to facilitating systemic improvements through the review and analysis of patterns of complaints and effective approaches to addressing issues.
25. Other human service sectors in Australia and overseas apply more stringent employment screening to people working with persons vulnerable to abuse. Options for strengthening probity screening include:

- The introduction of mechanisms allow for the application of 'unacceptable risk' testing.

- More readily accessible, nation-wide probity screening processes.
- Cross-sector collaboration to develop common mechanisms for services provided to various vulnerable populations, such as older people, young people and people with mental illness.

26. Long term strategies to raise professionalism include raising pre-entry qualification and ongoing training requirements; improving wages and conditions; improving career paths; and raising the valued status of the work.

SAFER SERVICE SYSTEMS

27. There are few practical examples of implementation with regard to risk assessment in disability services. Examples that have been identified require further testing and development for broad application.
28. Further work is needed to develop more sophisticated of tools to measure individual risk.
29. Disability programs across Australian jurisdictions have developed policies and procedures for preventing and responding to abuse. There is a lack of information available pertaining to the evaluation of their effectiveness.

RESPONDING TO ABUSE OR RISK OF ABUSE

30. Directions for how direct service delivery staff respond immediately and appropriately to incidents, allegations or suspicions of abuse need to be readily available and at-hand.
31. Training for support providers is required on how to identify the signs of abuse and neglect.
32. There are many factors that impinge on the under reporting of abuse identified in the literature.
33. Elements of an adult protection system include defining 'vulnerable' and identifying conditions for intervention; guardianship; reporting – voluntary or mandatory; and protecting whistleblowers.
34. Responding effectively to abuse requires coordinated interagency responses at the local area level, between agencies including but not limited to:

- Disability support services.
- Police and law enforcement agencies.
- Criminal justice personnel.
- Assault and crisis support agencies.
- Advocacy organisations.

35. Improving access to justice for people with a disability is likely to improve reporting and responding to abuse, including increased support for victims and perpetrators who have a disability.
36. Strategies for improving access to justice include:

- Addressing barriers to people with a disability giving evidence.
- Training and cross-sector collaboration.

- Providing advocacy support to people with a disability within the criminal justice system.
- Diversion and intervention programs for people with a disability who are in contact with the criminal justice system.

37. Social crime prevention is an approach to abuse prevention that may be applied within disability programs in a number of ways. This approach requires the accurate identification of crime within a defined community or environment and cross-sector collaboration to develop and implement strategies for reducing crime incidence.

CHILDREN WITH A DISABILITY

38. Strategies to address the abuse of children with a disability include:

- Effective family supports;
- The development and application of tailored self protection education programs in schools;
- Collaboration to prevent over compliance being taught to children; and
- Multi-disciplinary training and collaboration with child protection response personnel to improve responses for children with a disability.

39. A combination of risk reduction and health promotion in preventing child abuse has been recommended following a significant review of current and recent social or community based approaches.

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LEGISLATION

AUSTRALIAN LEGISLATION

Australian Standard AS4269 1995

Commonwealth Aged Care Act 1997

Commonwealth Disability Services Act 1986

Commonwealth/State Disability Agreement (CSDA)

ACT Disability Services Act 1991

NSW Children and Young Persons (Care and Protection) Act 1998

NSW Community Services (Complaints, Reviews and Monitoring) Act 1993

NSW Crimes Act 1900

QLD Whistleblowers Protection Act 1994

VIC Intellectually Disabled Persons' Services Act 1986

WA Disability services Act 1993 (section 53)

WA Criminal Law (Mentally Impaired Defendants) Act 1996

INTERNATIONAL LEGISLATION

Californian Waters Child Abuse Prevention Training Act

California created the Elderly and Dependent Adult Abuse Reporting Law in 1983

Pennsylvania Adults Protective Services Act (Amendment 1997)

USA Developmental Disabilities Assistance and Bill of Rights Act (1994 and Supp 1998)

USA National Crime Victims with Disabilities Act, 1998

CSDA DISABILITY PROGRAMS PUBLICATIONS & POLICIES

ACT Community Care Policy: *Response to Physical Assault, Sexual Assault, Emotional Abuse and Neglect*

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- Policy on employee recruitment and selection.
- Policy on employee and volunteer code of conduct.
- Policy on use of volunteers.
- Policy on police clearances for employees and volunteers.
- Behaviour Intervention and Support Policy.

APPENDICES

APPENDIX 1: CHARTER OF RIGHTS AND RESPONSIBILITIES

SOURCE: Reproduced from the Australian Commonwealth Department of Health and Aged Care website: http://www.health.gov.au/ *current at July 2000.*

AUSTRALIAN COMMONWEALTH AGED CARE ACT CHARTER OF RESIDENTS' RIGHTS AND RESPONSIBILITIES

A. Each resident of a residential care service has the *right*:

- to full and effective use of his or her personal, civil, legal and consumer rights;
- to quality care which is appropriate to his or her needs;
- to full information about his or her own state of health and about available treatments;
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to personal privacy;
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination;
- to select and maintain social and personal relationships with any other person without fear, criticism or restriction;
- to freedom of speech;
- to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions;
- to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, his or her financial affairs and possessions;
- to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;
- to have access to services and activities which are available generally in the community;
- to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;
- to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally;
- to complain and to take action to resolve disputes;
- to have access to advocates and other avenues of redress; and
- to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

B. Each resident of a residential care service has the *responsibility*:

- to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment;
- to care for his or her own health and well-being, as far as he or she is capable; and
- to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

APPENDIX 2: CONSUMERS OF CSDA-FUNDED SERVICES ON A SNAPSHOT DAY

SOURCE: The data below was reproduced from the Australian Institute of Health and Welfare *Disability Support Services 2000: First National Results On Services Provided Under The CSDA* available at www.aihw.gov.au.

SERVICE TYPE	CONSUMERS
ACCOMMODATION SUPPORT	
Institutions/large residentials	4,921
Hostels	781
Group homes	9,498
Attendant care	1,113
Outreach/other 'in-home'/drop-in Support	4,447
Alternative family placement	114
Accommodation support: other/not stated	554
Total Accommodation Support	*21,358*
COMMUNITY SUPPORT	
Early childhood intervention	2,128
Recreation/holiday programs	2,680
Therapy (PT OT ST)	3,277
Family/individual case practice/management	2,738
Behaviour/specialist intervention	688
Counselling: individual/family/group	338
Brokerage/direct funding	2,856
Mutual support/self-help groups	876
Resource teams/regional teams	1,704
Community support: other or not stated	602
Total Community Support	*17,017*
COMMUNITY ACCESS	
Continuing education/independent living training/adult training centres	3,939
Post-school options/social and community support/community access	8,217
Community access and day programs: other/not stated	2,625
Total Community Access	*14,660*
RESPITE	
Own home respite	372
Respite: centre/respite home	1,143
Respite: host family/peer support	239
Respite: other/flexible/combination	868
Total Respite	*2,598*
EMPLOYMENT	
Open employment	4,277
Supported employment	11,456
Open and supported combined	1,716
Total Employment	*17,373*
TOTAL	**62,341**

Notes:

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Totals may not be the sum of the components since individuals may access more than one service type on the snapshot day. There were 35 consumers who accessed services in more than one State or Territory.
2. Data for consumers of CSDA-funded services with service types Advocacy, Information/referral, Combined advocacy/information, Print disability/alt. formats of communication, Service evaluation/training, Peak bodies, Research/development and Other were not collected

APPENDIX 3: CODE OF CONDUCT ON SEXUAL ACTIVITY

SOURCE: The text below is an extract from the booklet *Caring for young people and the vulnerable? Guidance for preventing abuse of trust*; produced by the Home Office, Northern Ireland Office, the National Assembly for Wales, Department of Health, and Department for Education and Employment (UK). The UK Government provide this guidance to service providers, it contains model principles and content requirements for codes of conduct for sexual activity within relationships of trust. This guidance has not statutory enforcement.

A **Code of Conduct** on sexual activity between individuals within a relationship of trust should contain the following points:

- **A clear policy statement on the paramount need to safeguard and promote the welfare of young people/vulnerable adults** and protect them from sexual activity from those looking after them within a relationship of trust. This should make it clear that those taking on work or already working with young people/vulnerable adults must be aware that they are in a position of trust and the responsibilities this brings with it; and that they are bound by the Code. It should also make clear that the purpose of the Code is two-fold:
  - it aims to protect the young person/vulnerable adult being looked after from an unequal and potentially damaging relationship; and
  - it aims to protect the person in a position of trust by preventing him/her from entering into such a relationship deliberately or accidentally by providing clear and enforceable guidance on what behaviour is acceptable.
- **An explanation of the relationship between the Code on abuse of trust and policies and procedures for safeguarding young people and vulnerable adults more widely from other abuse.**
- **An explanation of the circumstances in which a relationship of trust will arise and the responsibility that arises from that relationship**. In broad terms a relationship of trust will arise where one party, through their work or activity, whether paid or unpaid or as a volunteer, has responsibility for the care of a young person/vulnerable adult in a way which gives them power or influence over him/her. The circumstances will vary in each organisation. If a list of circumstances in which such a relationship of trust is present is produced, it should normally not be viewed as exhaustive. Posts may need to be reviewed on a regular basis to take account of any changes of responsibility.
- **A definition of those to be protected by the Code**. In some circumstances this might possibly cover those, such as close friends or siblings of those in foster care, who are outside the immediate relationship of trust but come into close contact with the carers, but this would depend on the individual circumstances to be dealt with in each code.
- **A clear statement that any behaviour which might allow a sexual relationship to develop between the person in a position of trust and the individual or individuals in their care should be avoided; and that any sexual relationship within a relationship of trust is unacceptable so long as the relationship of trust continues.**
- **A clear supporting explanation of what behaviour is or is not acceptable within the particular organisation.** This is particularly important in areas such as sports coaching which may involve non-sexual physical contact or in care situations where intimate services may need to be performed for another person. This will need to be worked out in detail for each organisation but unacceptable activity would include sexual intercourse, masturbation, and oral sex or other sexual activity. This is not an exhaustive list. An objective test of sexual activity is important in

this context i.e. what a reasonable observer would consider was sexual in all the circumstances. Thus some behaviour, such as cuddling another person when they are hurt or distressed or spontaneous activity such as celebratory embraces, for example on the sports field, would not normally be construed as sexual. Guidelines are needed in each area to help avoid misunderstanding or misuse of the Code.

- **A clear statement that all those in the organisation have a duty to raise concerns** about behaviour by staff, managers, volunteers or others which may be harmful to those in their care, without prejudice to their own position.
- **A clear statement that the principles apply irrespective of sexual orientation**: neither homosexual nor heterosexual relationships are acceptable within a position of trust; and that they apply equally to all without regard to gender, race, religion, sexual orientation or disability.
- **The detailed procedures to be put in place**; the Code should serve to protect the young person/vulnerable adult from abuse of trust; it should also serve to help organisations to deal properly with false, malicious or mistaken allegations of abuse of trust and contain safeguards to protect those maliciously, falsely or mistakenly suspected or accused; it should be constructed to protect both the young people/vulnerable adults and those in a position of trust; the procedures should include:
- **how to ensure abuse of trust is identified if it occurs;** this includes ensuring a culture of openness within the organisation; that the young people/vulnerable adults know their right to say "no" and know that sexual relationships with staff are not allowed; it also means ensuring that they know what to do if they believe that they have been subjected to inappropriate behaviour; for example, consideration could be given to nominating a single named person within an organisation to whom the child/vulnerable adult knows they can turn to, to discuss concerns or receive advice in confidence;
    - **what to do if abuse of trust is reported or suspected;** this includes procedures for reporting concerns, whistle blowing, and the action the organisation should take when a complaint is made; it will need to reflect the internal processes of each organisation and should identify the person, both within and outside the organisation, to whom the complaint should be made; if a complaint is made it is good practice always to ensure that the particular relationship of trust is suspended until the matter is resolved;
    - **how to minimise the risk of situations** where abuse of trust could occur or relationships which could lead to abuse of trust could develop; or where false, malicious or mistaken accusations might be made; in looking at this, organisations will need to consider how to disseminate the codes; this might involve training and support for staff and monitoring arrangements, depending on the organisation concerned, and could form part of such arrangements already in place to prevent sexual or other forms of abuse;
        - what an individual should do if they are concerned they are developing a relationship which could represent an abuse of trust;
        - what an individual should do if they are concerned the other person is becoming attracted to them; what an individual should do if they are concerned a colleague is becoming attracted to someone in his/her care; and
        - what an individual should do if they are concerned that their actions or words have been misunderstood.
- The sanctions for abuse of trust; the seriousness of the abuse of trust should be reflected in the sanction. This is an area which should always be taken very seriously with dismissal as a possible sanction.

APPENDIX 4: COMMON INDICATORS OF ABUSE AND NEGLECT

SOURCE: Health And Welfare Canada (1993) *Community Awareness And Response: Abuse And Neglect Of Older Adults.*

COMMON INDICATORS OF ABUSE AND NEGLECT

Physical Abuse:

- unexplained injuries such as bruises, burns, swellings
- injury for which explanation does not fit evidence
- delay in seeking treatment
- injury to scalp, evidence of hair pulling
- symmetrical grip marks, evidence that the person has been shaken

Psychological or Emotional Abuse:

- fear
- withdrawal
- low self esteem
- extreme passivity
- older person appears nervous around the caregiver

Financial Abuse or Exploitation:

- unexplained discrepancy between known income and standard of living
- an older person has signed a document (e.g. will, property deed) without full understanding
- possessions disappearing
- if you work in a financial institution: an older person is surprised by an overdrawn or lower-than-expected bank balance; unusual transactions conducted on behalf of an older person by a third party

Sexual Abuse:

- pain, bruises, bleeding in genital area

Medication Abuse:

- reduced mental or physical activity
- depression
- reduced/ absent therapeutic response

Denial of Civil/Human Rights:

- difficulty visiting, calling, or otherwise contacting an older person
- older person makes excuses for social isolation

Neglect:

- malnourished, dehydrated
- missing dentures, glasses, hearing aid
- unattended for long periods or tied to bed/chair
- unkempt appearance - dirty or inappropriate clothing
- untreated medical problems

APPENDIX 5: RESPONDING TO CONSUMER TO CONSUMER ASSAULT

SOURCE: The text below is reproduced from the Executive Summary section of the report: Kennedy R. & CO PTY LTD for the Ageing and Disability Department, (1997) *Development of a Policy Framework on the Prevention of Consumer to Consumer Assault in Funded Disability Services*, NSW Ageing and Disability Department.

Elements and Key Principles to inform the development of good practice In Responding to Consumer to Consumer Assault, include:

1. **The need for legal intervention**-
   - Mandatory to call police if a crime has been alleged- People with disabilities should not be above the law.
   - People with disabilities who have been assaulted must be informed of their legal rights.
2. **Ensuring the safety of consumers**
   - Separate victims and perpetrators.
   - Wherever possible, victim should remain in the service and the perpetrator be relocated.
3. **Assistance to victim**
   - Assault mustn't be ignored.
   - Immediate access to medical attention, legal and counselling services.
4. **Assistance to perpetrator**
   - Access to legal support & advocacy where police have been contacted.
   - If consumer has a history of abuse, this must be addressed in their individual service plan.
5. **Appropriate staff training and supervision**
   - Staff trained to respond appropriately to incidents of assault.
   - Untrained staff should not be left in charge of services.
6. **Appropriate decision-making and reporting protocols**
   - Staff to record all incidents of assault and report to management.
   - Staff must be provided with clear policies and direction on responding to assault.
   - Clear lines of responsibility to ensure that immediate action can be taken.
   - Where perpetrators moved to a new service, the new service must be provided with adequate information about the perpetrator's history of abusive behaviour.
7. **Referral to mainstream and specialist services**
   - Both victims & perpetrators to be referred to appropriate mainstream and specialist service providers e.g. legal, medical, sexual assault, counselling & advocacy.
   - Disability services should have a clear understanding of the role and function of relevant mainstream/specialist services and ensure appropriate referral protocols are established with them.

APPENDIX 6: BEST PRACTICE MODEL FOR USE OF PSYCHOTROPIC MEDICATION

SOURCE: The contents of this appendix are reproduced as they appear in Appendix 2 of the report*:* NSW Health (1997*) Psychotropic Medication in Nursing Homes, Report of the NSW Ministerial Taskforce, NSW Health*

Best Practice Model for Use of Psychotropic Medication in Residential Aged Care Facilities

Preamble

'Psychotropic medication' refers to drugs that have an effect upon an individual patient's mental state. Within the context of this document, psychotropic medication included antipsychotic, antidepressant, antimanic, anxiolytic and hypnotic drugs.

Behavioural disturbance and psychiatric symptoms are frequent manifestations of dementia but may occur with other psychiatric disorders.

- Disturbed behaviour is not an individual phenomenon. When these behavioural and psychiatric manifestations occur they can be distressing not only to the person with dementia, but his or her formal and informal carers and other residents around the affected person.
- It is accepted that there is a role for the use of psychotropic medication in the nursing home population. The purpose of guidelines should be to assist doctors prescribing and nurses administering psychotropic medication to optimise the use of the medications.
- Comprehensive assessment may reveal the trigger or cause of the behavioural disturbance. Therefore altering the patient's routine, avoiding activities that provoke anxiety in the person with dementia or by modifying the person's environment eg the provision of secure grounds for wandering, can assist in management.

  A whole range of interventions can be used. These may include warmth, affection, music, massage or favoured foods all of which have been reported to be able to ameliorate disturbing behaviours, or even prevent such behaviours developing.
- Special training in behavioural therapy might be necessary to equip formal and informal carers of residents presenting challenging behaviours
- Behavioural and environmental manipulation is to be preferred to medications or physical restraints. The impact of the environment on the behaviour of people in nursing homes, appropriate use of behavioural interventions and the subject of physical restraint are addressed separately to this model and included in an accompanying resource package for all staff of nursing homes.
- All interventions, both pharmacological and non-pharmacological, should be evaluated and evidence of benefit documented. Any deterioration of the resident's condition after commencement, change or withdrawal of any therapy should be documented.

Psychotropic Drug Use and Review

1. No psychotropic medication should be prescribed without the approval of the person with dementia, or if that person is no longer competent to give informed consent without the approval of person responsible as specified by the State legislation. The rights of residents in residential aged care facilities and their families regarding medication must be made known to them by brochures or any other suitable means.
2. If psychotropic medications are required then the lowest dose of medication necessary to achieve therapeutic effect should be used bearing in mind the need to titrate the benefits against the risks.
3. The older person is in general more susceptible to side effects from psychotropic medication and may manifest adverse and at times atypical or not previously described effects.
4. Psychotropic medication should be reviewed regularly by the general practitioner. Frequent review early in the course of therapy may be required. Timing of subsequent reviews should be

determined by the clinical circumstances. In most cases this will be no longer than six weeks (6) and in some cases up to twelve (12) weeks.

5. The term review means examining the therapy, confirming that it is still appropriate and optimal.
6. Decisions need to be made by the general practitioner based on experience with the individual patient and his/her response. Factors to be considered in a review should include:
   - the natural history of the underlying disorder
   - previous history of response to medication and effects of reduction in medication;
   - any long term side effects of the medication
   - intercurrent health problems
   - environmental circumstances
   - effects of any behavioural interventions
   - a possible reduction in the dosage of the medication
7. Accurate record keeping is imperative and in line with best practice. Documentation should include what decisions are made and how those decisions were determined. Medication forms should be designed to separate the use of PRN from other medications. Indications for PRN medication should relate specifically to the individual resident and must be documented.

General Recommendations

- That the Department supports the development of a Resource Package to accompany the Best Practice Model. This should include:
  - Behavioural assessment and intervention strategies
  - Draft Criteria, Summary Sheet, Assessments of Adverse Effects (Quality Medication Care - Chris Bonner)
  - Clinical indicators for the use of psychotropic medication
  - Guidance for dose reduction, side effects and specific behaviours where drugs should not be used
  - A list of clinically significant drug interactions
  - Issues on physical restraint (Restraint Working Party recommendations)
  - Guidance on relevant State and Commonwealth legislation concerning consent.
  - The Alzheimer's Association Help Notes
- Evaluation of individual patient medication regimens could be addressed best through a general practice peer review process. This could be facilitated by local Divisions of General Practice. Such an activity may attract Practice Assessment points for the General Practice Quality Assurance Program. It is recommended that NSW Health encourages the Divisions of General Practice to apply for Commonwealth project funding for implementation of a general practice peer review process which would meet the requirements of the Royal Australian College of General Practitioners Quality Assurance Program. Clinical indicators could be used in the peer review process. These need to be developed and be included in the Resource Package.
- Each nursing home should have a Medication Advisory Committee . The Guidelines Working Party supports the recommendations by the Australian Pharmaceutical Advisory Council (APAC) that these committees "develop, promote, monitor and evaluate activities which foster the Quality Use of Medicines in Residential Aged Care Facilities". This is really not practical for individual patient medication review but should be in place for general policy development.

  Although a Medication Advisory Committee is recommended, there needs to be collaboration between **all** parties and future consideration given to more formal collaborative processes.
- That NSW Health investigate a mechanism for accredited community pharmacists to play a role in assessment of medication orders and education of staff.

- That NSW Health give consideration to providing resources to address the accommodation needs of different populations and issues relating to staff numbers and skills mix.
- That NSW Health recommends further development of Area Psychogeriatric Services:
    - To provide consultative services for residents from residential aged care facilities referred to them
    - to provide alternative accommodation to those people whose behaviours are inappropriate for general nursing homes
    - to provide psychogeriatric beds for acute assessment and management of nursing home and community patients requiring such services.
- That NSW Health address the funding requirements for Medication Advisory Committees.
- That NSW Health consider providing resources to facilitate research into the use/benefits of non-pharmacological behaviour modification strategies.