

# **Papering Over the Cracks: The Veneer of Prevention**

## **The Report From**

**The QPPD Community Investigation Into The Abuse, Assault  
And Neglect Of People With A Disability Receiving Services  
Provided Or Funded By Disability Services Queensland (DSQ).**

**About QPPD**

QPPD is a statewide systems advocacy organisation, established in 1981. QPPD conducted a number of advocacy ventures by parents during the 1980's covering issues including family support and respite, education, quality lifestyles for adults and guardianship. Since 1990 QPPD has been funded under the Disability Services Act from the Commonwealth Government to do statewide systems advocacy on behalf of people with disabilities. QPPD's mission is:

QPPD vigorously defends justice and rights for people with disabilities by exposing exclusionary practices, speaking out against injustices and promoting people with disabilities as respected, valued and participating members of society.

In addition to this systems advocacy focus, QPPD continues to develop a wide membership of families and friends across Queensland who remain in contact with the organisation. As well as personally supporting one another, these families take up issues collectively on behalf of sons, daughters and others, speaking out against injustices and promoting people with disabilities as valued and participating members of society.

**QPPD's advocacy principles**

Advocacy is speaking, acting, writing with minimal conflict of interest on behalf of the sincerely perceived interests of a disadvantaged person or group to promote, protect and defend their welfare and justice by:

- Being on their side and no-one else's
- Being primarily concerned with their fundamental needs
- Remaining loyal and accountable to them in a way which is emphatic and vigorous and which is, or is likely to be, costly to the advocate or the advocacy group.

**QPPD's position on what keeps people with disabilities safe?**

- We know people with disabilities are at risk of being labelled, abused, exploited, neglected or rejected. Protection from these risks has often resulted in services which attempt to provide for their needs in specialised places away from community and with different cultural and social norms. When people with disabilities are connected to community, they are safer, more respected, have greater opportunities and more enriched lives and are more likely to remain connected with family, friends and the wider community and to develop and have relationships.
- We believe that to keep people with disabilities safe means people with disabilities and families need authority to decide who they will live with, who will support them and what those supports look like. Where people have more direct say over their lives, they are less likely to be abused and neglected.
- People with disabilities are entitled to have the right to participate in decisions that are fundamental to the provision of support, including authority over the resources that are used to support their lives.
- Government and non-government services must be accountable to the people they serve. People with disabilities and their families are entitled to monitor, respond to and report harmful service practices and service breaches.
- We believe that society must foster positive attitudes towards disability to counteract society's prejudices so that people with disabilities and their families are able to achieve their rights and entitlements as valued citizens of Australia.

**Foreword by the President of QPPD**

For over twenty-four years, QPPD has held a positive vision for the lives of people with disabilities and their families. This vision emphasises the importance of meaningful relationships in people's lives and involves advocating for communities that value and benefit from the diversity of everyone's experiences and abilities.

QPPD's strong desire to improve the lives of people with disabilities and their families has fostered many important projects. I regard the following Community Investigation as a critical project that QPPD has undertaken to achieve our purpose, because unless governments and communities address issues around abuse, assault and neglect of people with disabilities, we cannot hope to achieve our visions and dreams for people with disabilities and their families.

For people to dream, they need to feel safe to do so. This is not rocket science. Yet, sadly, this report highlights that there are many people with disabilities who are not safe, and families are impeded in protecting their loved ones by a system that fails to listen to their concerns. If service providers and governments are not willing to listen and appropriately respond to people with disabilities around fundamental human rights issues, then they cannot profess to value such people.

We sincerely thank the contributions of many to this report and in particular to those who have had the courage and tenacity to share their own personal stories. Thank you for your belief in what we do.

It is with great hope that we present this report. We present it to those with the power to do something positive in the lives of people with disabilities and their families in the expectation that they will respond.

*Kathy Ellem*  
President

**Acknowledgments**

Queensland Parents for People with a Disability extends its heartfelt thanks for their contribution and support to the following people.

We acknowledge and thank the people who contributed to this investigation and were willing to share their experiences and knowledge. We recognise your courage to reveal very private and painful insights into your lives.

The Steering Group who have driven and shaped the investigation and this report: Judy Collins, Roz Cooper, Christine Douglas, Lindsay Dyball, Kathy Ellem, Marie Knox, Jude Lang, Lisa Lehmann, Morrie O'Connor and Jane Warner.

The Management Committee of QPPD who have provided direction, guidance and oversight of this project.

The Staff members who support the advocacy work of QPPD with a strong team effort and commitment: Sally Barone, Donna Best, Sandra Kalms, Sharyn Pacey, Stephanie Pratt and Anita Rooney.

And we thank the many organisations and individuals who assisted the investigation by distributing information, posters and the package to a wide network of people.

**Contents**

<b>About QPPD .....</b>	<b>ii</b>
<b>QPPD’s advocacy principles.....</b>	<b>ii</b>
<b>QPPD’s position on what keeps people with disabilities safe?.....</b>	<b>ii</b>
<b>Foreword by the President of QPPD .....</b>	<b>iii</b>
<b>Acknowledgments .....</b>	<b>iv</b>
<b>Contents .....</b>	<b>2</b>
<b>Executive Summary.....</b>	<b>4</b>
<b>Introduction.....</b>	<b>7</b>
<b>Background to this QPPD Investigation .....</b>	<b>9</b>
<b>The DSQ Policy .....</b>	<b>10</b>
<b>DSQ Complaints Management System .....</b>	<b>10</b>
<b>Purpose of the project.....</b>	<b>12</b>
<b>Method .....</b>	<b>13</b>
<b>Obscuring the Objective of Legislation? .....</b>	<b>15</b>
<b>Findings.....</b>	<b>18</b>
<b>The Tip of the Tip of the Iceberg.....</b>	<b>18</b>
<b>Discussion.....</b>	<b>23</b>
<b>Critical Issues .....</b>	<b>28</b>
<b>1. The extent and nature of abuse, assault and neglect of people with disabilities within disability services .....</b>	<b>28</b>
<b>2. The emotional, physical and financial costs of abuse, assault and neglect .....</b>	<b>38</b>
<b>3. The current trends in disability service provision including staff training and work practices.....</b>	<b>45</b>
<b>4. The effectiveness of the DSQ Policy <i>Preventing and responding to the abuse, assault and neglect of people with a disability</i> .....</b>	<b>48</b>
<b>5. How complaints are handled by DSQ.....</b>	<b>51</b>
<b>6. The level of satisfaction of complainants about the resolution or otherwise of their complaint .....</b>	<b>51</b>
<b>7. Other Service Systems .....</b>	<b>59</b>
<b>8. Developing Strategies.....</b>	<b>61</b>

**Key Findings and Conclusion..... 63**

**Recommendations..... 65**

**APPENDICES..... 68**

**Appendix A - Outline of the key elements of the policy..... 68**

**Appendix B - QPPD Community Investigation Questionnaire ..... 72**

**Appendix C - QPPD Community Investigation Booklet ..... 80**

**Appendix D – Optional Reply Form ..... 88**

**References and Further Reading..... 89**

**Executive Summary**

This report details the results of an investigation conducted by QPPD into the effectiveness of the Disability Services Queensland (DSQ) policy, *Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability*.

The investigation sought to discover if this policy did prevent the abuse, assault and neglect of people with a disability receiving services provided or funded by Disability Services Queensland (DSQ) by examining the first three years of operation of this policy and reflecting on the lived experience of people with disabilities, their families, friends and advocates. To gather information an information booklet, questionnaire and optional reply form were distributed throughout Queensland from October 2004 and responses requested by 31<sup>st</sup> January 2005. QPPD received 120 written responses.

The key findings of this report are:

1. People with disabilities still experience abuse, assault and neglect within disability services. The extent of abuse, assault and neglect has not diminished in any significant way, nor has the introduction of the policy had an effect of any consequence.
2. The nature of abuse, assault and neglect that people continue to experience ranges from life-threatening, cruel, inhuman and degrading to disrespectful and disdainful neglect.
3. The consequences of the abuse, assault and neglect people have experienced are long-term and devastating for people with disabilities, their families, friends, allies and advocates.
4. Current trends and practices of disability service provision do not reflect the knowledge gained from evidence about ongoing abuse, assault and neglect and the consequences.
5. DSQ introduces strategies and mechanisms, conducts reviews and implements new systems in splendid isolation, resulting in a constant 'tweaking' of the system and with no consideration of the impact of such constant revision on the people who are served by the system.
6. The DSQ Policy is revealed to be ineffective in preventing abuse, assault and neglect. It operates as a response mechanism at best and a diversion from the truth at worst.
7. The DSQ Complaints Management System (CMS) is unable to handle complaints of this nature. Delays in process expose people to further risk and resolution of complaints is unsatisfactory; the CMS cannot deliver justice for people with disabilities or protect complainants.
8. The judicial system is unresponsive and inflexible in its approach to cases which reach the courts.

9. The Queensland Government has not adopted a whole-of life approach to the issue of abuse, assault and neglect and as a consequence there is little cross-service collaboration to address the issues.
10. People with disabilities, their families, friends and allies are denied significant decision-making opportunities and their wishes and needs are often ignored, overridden or discounted.

There is a need to acknowledge that people with disabilities have been subjected to violent and inhumane treatment for a very long time. The “special” reporting system represented by DSQ policy and in particular, the DSQ policy, *Preventing and Responding to the Abuse, Assault and Neglect of People with Disability* is not providing real protection.

As fellow human beings we are obliged to acknowledge this and create the conditions for a paradigm shift to occur. People with disabilities must have the same right to achieve justice, without fear of rejection and without being further victimised. People with disabilities will have more chance of being supported to have a safe and good life when all of society recognises and supports this.

We recommend to DSQ the following suggestions for law and policy reform. And we recommend the following to each and every one of us to reflect on our personal response.

People with disabilities who use services will be safer when:

1. People with disabilities choose where and with whom they live.
2. People with disabilities choose who supports them.
3. People with disabilities choose their own source of independent advocacy and support.
4. Training is provided to people with disabilities and their families on their rights and responsibilities as employers and board members.
5. Services conduct pre and in-service training to management and support workers in human rights, ethics, and values.
6. Services ensure management personnel are fully-trained in all aspects of service provision and conduct regular support work as part of their management role.
7. All services, but in particular those with segregated and/or congregated settings, are supported to move to individualised, person-centred responses.
8. People with disabilities, families, friends and advocates have full and equal representation on the boards of services.

9. Services adopt a 'do the least harm' approach and are open to monitoring by family, friends and advocates on an ongoing basis.
10. A review of the roles and powers of the Office of the Adult Guardian, the Community Visitor Scheme and the Office of the Public Advocate is conducted.
11. Service agencies, of all types and however funded, Government, private or non-funded, must be accountable to an independent agency with full jurisdiction to apply necessary penalties.
12. Quality Standards are applicable to all other Queensland Government Departments involved in providing services to people with disabilities.
13. The *Disability Services Act* is amended to recognise the authority of the DSQ Complaints Management System.
14. The DSQ Complaints Management System has powers to investigate all service complaints other than those of abuse, assault and neglect.
15. *The Whistleblowers Act* is amended to include protection for non-DSQ staff.
16. An independent human rights commission must be set up to oversee all human service agencies and support services.
17. The investigation of allegations of abuse, assault and neglect to be conducted by an independent body which is part of the criminal justice system, with full powers of criminal enforcement, and separate from the DSQ Complaints Management system.
18. The scope of the *Queensland Criminal Code* is extended to allow third parties to press charges of abuse, assault or neglect on behalf of a person with disabilities who is unable to communicate.
19. Training is conducted in appropriate interview and response techniques for police, courts and others involved in the criminal justice system.
20. Training in prevention awareness and personal safety education is provided for people with disabilities.
21. Mandatory tertiary training for counsellors, psychologists and other therapeutic professions to develop an understanding and awareness of the impact of disability.

## **Introduction**

People with disabilities and their families in Queensland frequently rely upon the services of others in their daily lives. In addition to the informal networks of friends, neighbours and community connections such as church groups and volunteer organisations, formal service networks too have a long history of providing support to people with disabilities and their families. Most people with disabilities live at home and are supported by their families; others rely on formal services entirely for a whole range of support and some on a mix of formal and informal support. However, with an ageing population, the growth in demand for formal services is expected to continue into the foreseeable future.<sup>1</sup>

As a consequence, formal service systems in Queensland have grown larger and more complicated, with complex organisational structures, policies, procedures and guidelines. Government legislation and regulations lead to further complexity and revision of systems. Disability Services Queensland (DSQ) was formed out of the Department of Families Youth and Community Care (DFYCC) as part of a revision of the system. DSQ continues to evolve internally and as part of the whole of government. The evolution of the disability services system does not guarantee improvements in service delivery for the people who use services; often evolution is funding rather than needs-driven, the 'in-thing' rather than reality-driven or 'knee-jerk' rather than comprehension-driven. Whole service systems sometimes end up looking rather like the Hydra of Ancient Greek mythology and as Hercules found in his task to defeat the Hydra, by trying to remove one problem, many new ones are created.

Any system, however well-intentioned, can be undermined by increasing complexity, a lack of planning or inept planning, incomplete or inappropriate implementation and the foresight required to consider all of these and project for the future. A flawed system, apart from being inevitably found to be wanting in many areas, will receive constant revision with piecemeal solutions to those problem areas. The boundaries of a flawed system can also be relatively simple to breach, administratively, by weakening the intrinsic purpose of the system and by using the failings of the system to enable individual and systemic harm. In a human service system like DSQ-direct and funded service organisations, the people served are the ones most exposed to harm, both at an individual and systemic level.

Repeated evidence and exposure of ongoing incidents of abuse, assault and neglect within DSQ-direct and funded services, together with a reform and review of funding provisions and disability services led to the introduction in

---

<sup>1</sup> Research conducted in 1995 by the Australian Institute of Health and Welfare (AIHW) found that 60.2% of people with a disability living in a household relied solely on informal assistance. 31.7% relies on a mixture of formal and informal and 8.1% on formal only. The research projected that as the principal support person ages, their capacity to fulfil the role will diminish resulting in increased demand for formal services. An AIHW study from 2003 confirmed this growth in unmet need and the subsequent provision of further government funding for disability services. Source:

[www.aihw.gov.au/disability/csda\\_public/index.html](http://www.aihw.gov.au/disability/csda_public/index.html)

2002 of the policy *Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability*.

This report examines the first three years of operation of this policy and reflects on the lived experience of people with disabilities, their families, friends and advocates. The report reveals through first-hand experiences and accounts that people with disabilities are still subjected to abuse, assault and neglect within services and suggests that a policy alone cannot stop such behaviour. Can anything truly eliminate abuse, assault and neglect? And if not, how do we best provide formal support to people with disabilities which reflects a genuine commitment to the needs of each individual to experience as full a life as possible on their own terms within community? Without commitment to injecting these positive values, principles and beliefs into service practice, to developing supports which reflect what people actually need and responding to rather than providing for people with disabilities and their families, then such paper-driven solutions to the abuse, assault and neglect of people with disabilities who use services is like arming Hercules with a cardboard sword.

**Background to this QPPD Investigation**

QPPD's mission statement outlines the guiding principles for the systems advocacy goals of the organisation.

QPPD vigorously defends justice and rights for people with disabilities by exposing exclusionary practices, speaking out against injustices and promoting people with disabilities as respected, valued and participating members of society.

Since 2001 QPPD has conducted a systems advocacy focus on the Queensland Government's system of support for people with disabilities and has lobbied for system reform to provide more flexible responses to the important issues in the lives of people with disabilities and their families. In this time QPPD has monitored and sought to influence the policies and practices of both government and non-government disability support services. Concerns raised by people with disabilities and their families revealed disturbing evidence about continuing issues of abuse, assault and neglect within services, which led QPPD to question whether the introduction of the Disability Services Queensland (DSQ) Policy *Preventing and responding to the abuse, assault and neglect of people with disability* had any significant impact? Through networking, information-gathering, and developing strategic alliances QPPD collected much evidence that showed people with disabilities continued to be abused, assaulted and neglected within services. Complaints about such treatments were often unresolved, subject to lengthy processes and even when resolved, were neither transparent, nor observable and were unlikely to set precedents for major system change.

These concerns prompted the organisation to develop this project to investigate the impact of the policy on people with disabilities and their families.

Central to the work of this project was the gathering of information about the effectiveness of the DSQ policy *Preventing and responding to abuse, assault and neglect of people with a disability*. This policy applies to all disability service providers funded by, or operated by DSQ.

## **The DSQ Policy**

In February 1999 a reference group was formed by the then Department of Families, Youth and Community Care (DFYCC), to develop a policy around abuse, assault and neglect of people with disability who were receiving services through department-funded or department-run services. The members of this reference group were drawn from a range of service providers, parent, 'consumer' and advocacy organisations<sup>2</sup> and departmental staff. At this time, some other States had developed policies or guidelines in relation to the prevention of abuse, assault and neglect, most notably Tasmania and NSW. As part of the process, a Queensland-wide consultation process to develop an abuse prevention policy, as well as other strategies, was undertaken by DFYCC, which reported its findings in November 1999. The policy, procedures and resource manual for *Preventing and responding to the abuse, assault and neglect of people with disability* was a major outcome of this process.

The policy became effective in February 2002. Information is provided as a policy document, a resource booklet for service providers and a leaflet. These documents may be found on DSQ's website.<sup>3</sup> A brief overview of the key elements of the policy and the resource booklet is included in this report in Appendix A.

The resolution of complaints of abuse, assault or neglect is through the Complaints Management System, which is outlined below.

## **DSQ Complaints Management System**

The Complaints Management System (CMS) was established in 2000 and handles complaints about disability services run or funded by the Queensland Government. A Complaints Management Quality Committee was formed to 'oversight the quality of the management of complaints under the Complaints Management System' in 2001. Both the CMS and the Committee refer to the policies:

*Policy and Procedures for Complaints regarding DSQ services* approved December 2000 and

*Policy and Procedures for Complaints regarding funded services* approved December 2000,

There is no direct reference to the Policy, *Preventing and responding to the abuse, assault and neglect of people with disability*, nor any indication how this policy interfaces with the complaints process, the CMS or the above-named policies. The DSQ website on its publications page lists the two complaints policies under the section entitled "Complaints": the Policy on

---

<sup>2</sup> QPPD, along with other advocacy groups, was involved in this reference group from January 1999.

<sup>3</sup> [www.disability.qld.gov.au/publications/abusepolicy](http://www.disability.qld.gov.au/publications/abusepolicy)

abuse, assault and neglect is listed under “Community involvement publications” and is not easily locatable.<sup>4</sup>

DSQ has produced its own brochure for services it operates, “Are you unhappy with a disability service? Do you want to make a complaint?”<sup>5</sup> and requires DSQ-funded service providers to develop and adopt an ‘easily accessible complaints procedure’.

The CMS, its complaints and disputes policies and procedures form part of the Disability Sector Quality System, which came into effect in July 2004 with initial certification audits of service providers expected to begin in 2005. All service providers must be certified by 2008. DSQ conducted information sessions during 2004 for service providers on the implementation of the new system and its requirements.

QPPD met and wrote to the Director-General of DSQ, Linda Apelt, on 30 June 2004 to request similar sessions to inform people with disabilities and families about the implementation of the Quality System<sup>6</sup>. At this point QPPD is not aware that any such information sessions are to be conducted.

The Misconduct Prevention Unit conducts investigations into DSQ-staff misconduct allegations and is responsible for reporting its findings to the Crime and Misconduct Commission (CMC). Neither the Misconduct Prevention Unit nor the CMC have jurisdiction over non-government services, even if they are funded by DSQ or any other government department.

---

<sup>4</sup> [www.disability.qld.gov.au/publications/abusepolicy](http://www.disability.qld.gov.au/publications/abusepolicy)

<sup>5</sup> [www.disability.qld.gov.au/complaints/complaints\\_brochure.pdf](http://www.disability.qld.gov.au/complaints/complaints_brochure.pdf)

<sup>6</sup> QPPD letter to Linda Apelt, dated 30 June 2004.

**Purpose of the project**

With the Queensland Government launching these and other new strategies and mechanisms under its Strategic Plan 2000-2005, QPPD decided to seek to uncover information and stories about the extent of abuse, assault and neglect of people with disabilities who receive services through DSQ-direct or funded services. A major focus of this work was to examine

- The effectiveness of the current and proposed policies on complaints and prevention and response to allegations of abuse, assault and neglect,
- If the proposed implementation of new or re-modelled mechanisms such as the Quality Framework and Disability Service Standards would effect real change in the lives of people with disabilities and
- How would government's response to service delivery cultures and practices that contravene human rights be different?

QPPD would explore and review the following areas in order to address these questions:

- The extent and nature of abuse, assault and neglect of people with disabilities within disability services;
- The emotional, physical and financial costs of abuse, assault and neglect against people with disabilities;
- The current trends in disability service provision including staff training and work practices;
- The effectiveness of the DSQ Policy *Preventing and responding to the abuse, assault and neglect of people with a disability*;
- How complaints are handled by DSQ; and
- The level of satisfaction of complainants about the resolution or otherwise of their complaint.

The project would document its findings in a report, which would serve as a tool to inform government, community and the direction of QPPD's advocacy efforts in relation to this priority.

## **Method**

In April 2004 the Management Committee of QPPD invited people to form a steering group to guide the work of the project. The steering group was selected on the basis of backgrounds, skills and knowledge. A group of ten people all with a diverse range of life experiences and expertise was formed: 5 parent members of QPPD and 5 allies of QPPD, 3 of whom are people with disabilities. The group's skills and knowledge included academic, counselling, involvement in community organisations and movements, involvement in DSQ or other service systems, advocacy skills and a shared perspective about the lives of people with disabilities within our society.

A Project worker was appointed in April 2004 to conduct the work of the project under the direction of the steering group. Decision-making responsibility for the project rested with the QPPD management committee, based on reports and recommendations from the steering group.

The Chairperson and three other members of the steering group are also members of the QPPD management committee. The steering group met for the first time in June 2004 and has continued to meet on a regular basis during the project. The first meetings established a process for the work of the project and a campaign name "*QPPD Community Investigation into the Abuse, Assault and Neglect of People with a Disability receiving services provided or funded by Disability Service Queensland (DSQ)*" which was ratified by the management committee in June 2004.

## **The Questionnaire**

The steering group developed a questionnaire (Appendix B) as the method for obtaining information about the issue of abuse, assault and neglect. The questionnaire was drafted by the group, legal opinion on privacy, confidentiality and legal responsibility was sought. Members of the steering group with academic backgrounds gave guidance on the methodology and a QPPD member telephone conference was conducted to ensure member awareness and support of the project and to enable members to contribute to the process.

The questionnaire was accompanied by an information booklet (Appendix C). This decision to incorporate an information booklet as part of the package arose out of concern for the well-being and protection of respondents. We considered that the re-visiting of traumatic events might be highly difficult for people and it was essential to give people information about where they might seek further support.

An optional green reply form (Appendix D) was included, together with a second reply-paid envelope; this was to protect the privacy and confidentiality of respondents while allowing them to continue to receive information on the investigation and other QPPD projects. In addition, if a follow-up study to the investigation was conducted, it was necessary to know how to contact people.

The initial timeframe for people to respond to the investigation was to be one month, beginning on the 1<sup>st</sup> November, 2004.

## **Publicity**

Prior to the 1<sup>st</sup> November 2004, a publicity campaign was developed to raise community awareness about the investigation. Advertisements were placed in all major regional and state-wide newspapers, a poster was designed and sent out across Queensland including to libraries, community organisations, regional DSQ offices, service providers, support groups and schools. A targeted media campaign, involving local and state radio interviews and a series of media releases was conducted. A stand-alone website was developed and a 1 800 telephone service was set up for people to request further information.

## **The Campaign**

At the beginning of November the Community Investigation package of questionnaire, information booklet and reply form was mailed to all QPPD members, large and small service organisations, community organisations, DSQ offices and services, support organisations, advocacy groups, individuals, the Minister and the Director-General of DSQ.

During the course of November 2004, QPPD received many requests for further packages, indicating a high degree of interest in the investigation, however responses were being returned at a slow rate. Given the high level of interest, it was agreed to extend the timeframe to the 31<sup>st</sup> January 2005.

All the responses were entered into a database. All information was collected and stored in paper or electronic format in accordance with the National Privacy Principles for protecting confidentiality and privacy.<sup>7</sup>

---

<sup>7</sup> *Commonwealth Privacy Act 1988.*  
*Privacy Amendment (Private Sector) Act 2000.*

**Obscuring the Objective of Legislation?**

Government introduces legislation to define, defend and protect the civil and human rights of its citizens and to detail measures for those who do not honour these. For most modern democratic governments, legislation is based on values and mores which descend from the dominant cultures of that particular society. Over time and in response to changing societal situations, some legislation, having no further legitimacy, is repealed and others, seeking to address these changing societal values, are amended or introduced as new legislation.

The most profound change in societal values had occurred over centuries in the recognition of who is and who is not a citizen. Many people and groups in society are now afforded rights and protection, who in previous times would not have been considered citizens. Some examples of the legislative response to this change are the laws on anti-slavery, human rights and equal opportunity, anti-discrimination, racial vilification, domestic violence, child protection, and sexual violence.<sup>8</sup>

Interpretation of our civil and human rights into administrative systems has become increasingly complex and many-layered. Administration of government is further regulated by policies, procedures, regulations and guidelines and is difficult for the ordinary citizen to negotiate.

Certain groups of people have come to be seen as more vulnerable than other citizens and the legislation often does not seem to afford them as much protection as other citizens, or their capacity to seek redress under law is reduced. Sometimes additional legislation is adopted to protect these vulnerable groups. People with disabilities constitute such a group and in Queensland specific laws have been passed to protect their civil and human rights.<sup>9</sup>

---

<sup>8</sup> Examples of Commonwealth of Australia legislation include:

Age Discrimination Act 2004  
Disability Discrimination Act 1992  
Equal Employment Opportunity (Commonwealth Authorities) Act 1987  
Equal Opportunity for Women in the Workplace Act 1999  
Human Rights and Equal Opportunity Commission Act 1986  
Human Rights (Sexual Conduct) Act 1994  
Privacy Act 1988  
Racial Discrimination Act 1975  
Racial Hatred Act 1995  
Sex Discrimination Act 1984

<sup>9</sup> As well as Commonwealth legislation, the human and civil rights of people with disabilities living in Queensland are enshrined in the

- Anti-Discrimination Act (Qld)1991,
- Child Protection (Offender Reporting) Act 2004
- Coroners Act 2003,
- Disability Services Act 1992 - under review as part of the Legislative Reform Project
  
- Education (General Provisions) Act 1989
- Education (Work Experience) Act 1996

Many governments adopt administrative processes designed to further protect the civil and human rights of the vulnerable; such processes are additional to the legislative process and are intended to enhance that process.<sup>10</sup>

In Queensland certain agencies exist, whose remit is said to be to assist people through some of these administrative and other processes:

The Office of the Adult Guardian  
 The Office of the Public Advocate  
 The Public Trustee of Queensland – Disability and Aged Support Service

The additional powers of these administrative agencies however are acknowledged as being very limited. In the Annual Report 2003-04, the Adult Guardian states:

The Adult Guardian has no legal power to investigate a facility or investigate industrial issues between staff and management at a particular site. The Adult Guardian also does not have powers to investigate systemic issues at a facility or similar facilities across Queensland. Systemic advocacy is a power reserved to the Public Advocate, though he does not have a specific investigation power. He also has a power to promote the protection of adults from abuse. This is not well understood even by those working in the field so the point is emphasised here.

There is no legal requirement or system in place for the notification of abuse, neglect or exploitation of adults with impaired capacity under the *Guardianship and Administration Act* or other Acts. The Adult Guardian has a statutory discretion whether or not to investigate a particular referral concerning alleged abuse, neglect or exploitation of an adult or adults with impaired capacity.<sup>11</sup>

- 
- Equal Opportunity in Public Employment Act 1992
  - Family Services Act 1987
  - Guardianship and Administration Act 2000
  - Guide Dogs Act 1972 Act 1998
  - Mental Health Act 1974
  - Mental Health Regulation 1985
  - Powers of Attorney Act 1998
  - Whistleblowers Protection Act 1994

<sup>10</sup> In Queensland these include Commissions and Tribunals such as:

The Anti-Discrimination Commission Queensland  
 The Anti-Discrimination Tribunal Queensland  
 The Commission for Children and Young People  
 The Children's Services Tribunal Queensland  
 The Guardianship and Administration Tribunal Queensland  
 The Mental Health Review Tribunal Queensland  
 The Crime and Misconduct Commission  
 The Misconduct Tribunal Queensland

<sup>11</sup> Office of the Adult Guardian. *Annual Report 2003-04*. Brisbane: Queensland Government. P4

If administrative processes are not enforceable through typical methods of legal redress and have little or no authoritative power, then there is a risk that they replace rather than reinforce legislative process and in fact set up a discriminatory framework for dealing with violent, abusive actions towards people with disabilities.

It is notable that very few situations involving potential victims from the general population permit potential criminal conduct to be investigated initially by administrative agencies, as is the case with victims with developmental disabilities. This represents a separate and unequal system of justice for crime victims with developmental disabilities.<sup>12</sup>

Abuse of people with disabilities seems to be often considered of less consequence than similar instances which occur in the general community and is often further sanitised by the use of less potent language to describe such offences:

Women with learning disabilities are “sexually abused” – other women are raped. Men with learning disabilities are ‘physically abused’ – other men are assaulted. Steal something from someone with learning disabilities and it is ‘financial abuse’, not theft. Offenders against the general community are criminals – those who victimise people with learning disabilities are ‘abusers’. William cited in Sherry (2000).<sup>13</sup>

The legal and administrative response to offences against people with disabilities seems to suggest that societal attitudes have changed little and may even contribute to endorsing some of the practices of human service systems.

(T)he way staff perceive and treat people with intellectual disabilities is significant. It has been suggested that abusive or corrupt care practices may be justified through a ‘neutralization of moral concerns’, whereby people with intellectual disabilities are perceived as less than fully human, with minimal rights and values.<sup>14</sup>

The objective of the vast array of legislation cited above is to promote and protect the civil and human rights of vulnerable people, however the complex and confusing layers of legislative and administrative process not only obscure this objective but also mask the reality that people with disabilities remain at great risk, with no real protection within the system. This investigation is a timely insight into this anomaly.

---

<sup>12</sup> *Abuse and Neglect of Adults with Developmental Disabilities: a Public Health Priority for the State of California*, (2003). P.17

<sup>13</sup> Sherry, M. (2000). P.2.

<sup>14</sup> White, C., Holland, E., Marsland, D. & Oakes, P. (2003). P.4.

## **Findings**

### **The Tip of the Tip of the Iceberg**

QPPD received 120 responses to the Community Investigation. It is widely acknowledged that abuse and assault reporting rates in general are lower than the actual incidence of these events<sup>15</sup>. It is also not unusual that this type of written survey generally elicits a poor response rate<sup>16</sup> and it is significant that we were unable to obtain any statistics on reported incidents from Queensland through the National Disability Service Abuse and Neglect Hotline. A discussion of the response rate and barriers to participation is included in a later section of this report. The discussion also includes analysis of the following statistics and the written, additional comments provided by respondents.

#### **Who took part?**

Family members made up the largest group of respondents (49%) to the investigation. People with disabilities were the second largest group (23%) and of the remaining third, the largest group was service workers and organisations (20%).

Approximately half of the respondents live in the Greater Brisbane area, the Sunshine and Gold Coasts and to the south-west of Brisbane in the areas of Ipswich and Toowoomba; the remaining half of respondents represented most other districts of Queensland or did not identify a postcode.

Over four-fifths of respondents said they receive, know, or work with someone who receives support from a DSQ-direct or DSQ-funded service (82%) however of the 18% who either did not answer or replied they did not receive support, it was evident from their comments that some received services through other human service systems, such as Queensland Health.

#### **What were they asked?**

The questionnaire sought information about awareness of the policy. How did people find out that there is a policy and were they familiar with the policy documents and the processes described therein?

Over half (52%) of the responses indicated that people are aware of the policy, however 32% said they had neither heard nor read about the policy, 3% didn't know if they had and 13% did not answer the question. The largest group of respondents who knew about the policy indicated that this information had been provided by or requested from DSQ (27%) and 13% indicated they had received the information from a service provider. Only one-third of all respondents said they had actually seen a copy of the policy

---

<sup>15</sup> An estimated 21,800 (77%) of the 28,300 female victims of sexual assault in 2002 considered their most recent incident a crime, yet 80% of victims did not tell police about the incident. Source: [www.abs.gov.au/Ausstats](http://www.abs.gov.au/Ausstats)

<sup>16</sup> A major disadvantage of self-completion surveys is the potentially high non-response. Source: [www.qgm.qld.gov.au/bpguides/conduct/coll.html](http://www.qgm.qld.gov.au/bpguides/conduct/coll.html)

document and resource booklet, with one-quarter stating they had seen a pamphlet.

People who had seen or had a copy of the policy documents had received them from DSQ (51%) or a service (17%) and some through lodging a complaint (5%); only 8.5% stated that they had asked for a copy and 8.5% also received it through an advocate or advocacy organisation. Only half of the respondents said they knew what the policy was for.

Forty per cent of the people who knew of the policy said the knowledge had helped them in making a complaint, twenty five per cent said it helped them to identify and stop abuse, assault and neglect and twenty one percent to improve service delivery or train staff.

A4. Have you used the policy or did knowing about the policy help you to:	
Make a complaint	25
Get information	17
Prevent bad things from happening	17
Stop bad things continuing to happen	16
Inform family or friend	15
Improve service practice	13
Train staff	13
Other	21

### What had happened?

The questionnaire then sought to discover what had happened and what had been the response to allegations of abuse, assault and neglect. The questions tracked three major themes. In addition, respondents were encouraged to include written responses in this section; these comments and accounts are discussed in a further section of this report in the analysis of major themes and issues.

Firstly, had respondents experienced or seen abuse, assault or neglect, when had this occurred, if it was reported by them and to whom and if they felt that the issue had been satisfactorily resolved. (Group of questions B1-B8)

Secondly, how the person or persons had reacted and if there had been any negative consequences for the person(s) involved and lastly what help or assistance did they receive and how would they deal with such an incident in the future. (Group of questions B9-B13)

To questions B1, "Have you seen or experienced abuse or assault?" and B2 "Have you seen or experienced neglect?" 82% answered yes and alarmingly, when asked when these incidents had occurred (B3), the responses indicate that of these more than one third were experiencing ongoing abuse, assault or neglect.

B3. When did this/these incidents occur?	
Ongoing	38
0-2 years ago	31

2-5 years ago	21
5-10 years ago	13
More than 10 years ago	11

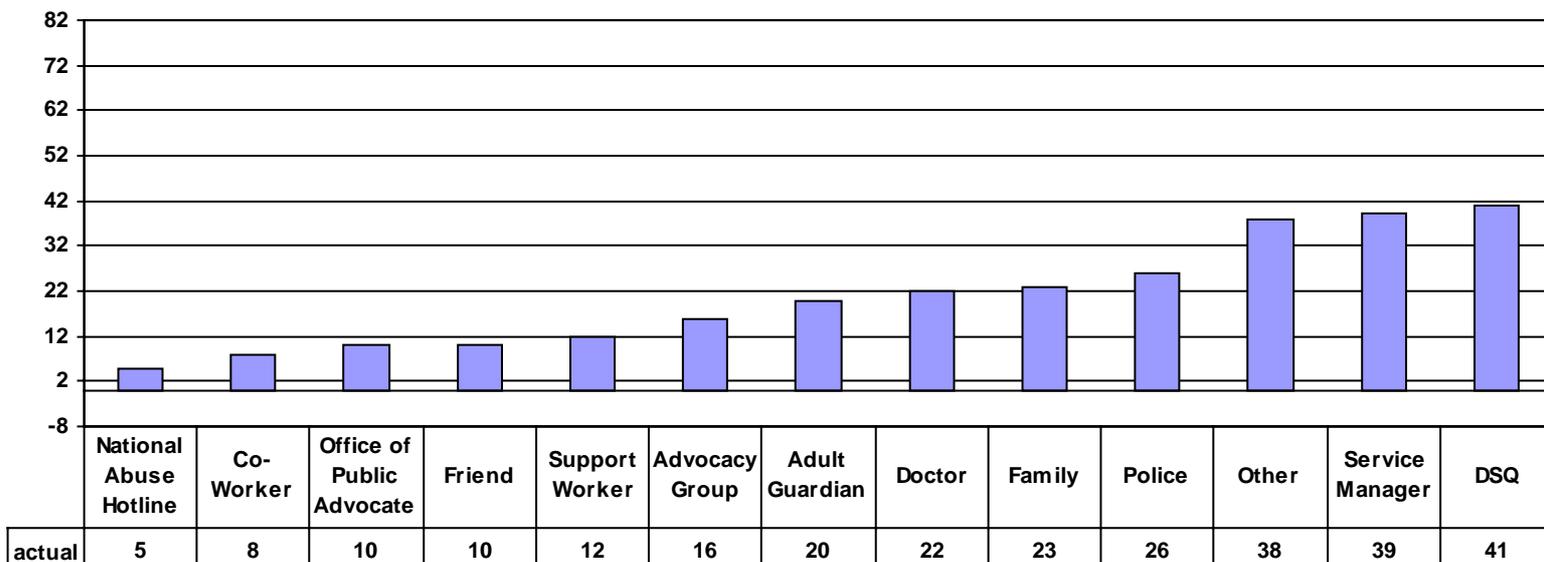
The percentage of people who reported these incidents was high at 74%, though 8.5% of the total number of respondents who had experienced or seen incidents had answered both yes and no to either question B1 and B2 and further analysis of their responses reveals that they were referring to more than one episode or incident of abuse, assault and neglect in their response. People said they did not report the incidents for the following reasons:

B5 If no, why not?	
Lack of evidence	11
Fear of retaliation	9
Didn't know enough	9
Didn't know what to do	6
Didn't realize it was abuse, assault or neglect	3
Advised not to	1
Other	13
* more than one box ticked	

The remaining questions, B6 to B12, in this section concern those people who did report an incident. People were asked to note who they reported the incident to and were encouraged to tick more than one box.

Most people reported an incident to the service or DSQ, many respondents had reported the incident to more than one authority and those who noted that they had reported it elsewhere listed the Minister and Premier, local politicians and federal agencies and politicians among those contacted.

**B6. Who did you report this incident to?**



Of the 82 people who responded to the question “Do you feel this issue was resolved, a significant percentage (71%) reported that they did not feel the issue was resolved while only 20% stated that they considered the issue resolved. The remaining 9% were either unaware of or awaiting the outcome. The comments of respondents as to why or why not the issue was resolved are discussed later in this report.

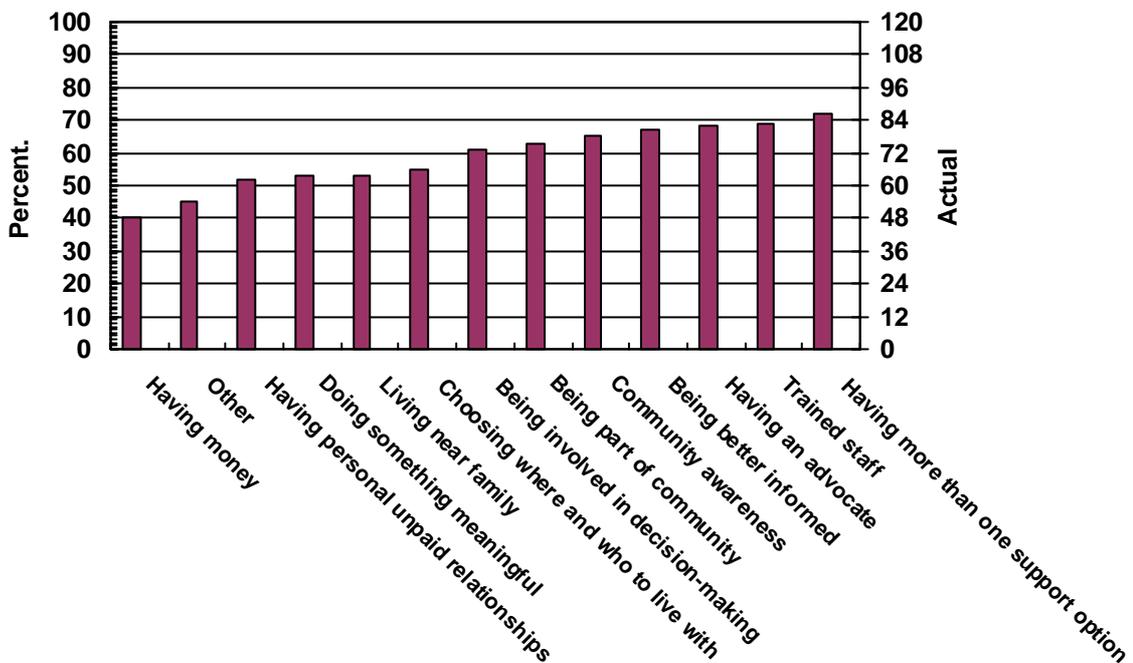
Over half of these respondents said that someone was badly treated because the incident was reported to someone.

When asked if they were given any help either of a practical or emotional nature, to make their complaint, over two-thirds said they were not and of the 30% who were given some assistance, 77% received independent outside help or assistance from an independent advocate.

**What *might* help?**

The third and final section of questions (C1 and C2) were about prevention strategies and were targeted at discovering if people thought a policy helps to keep people with disability safe and what other measures did people consider would contribute to keeping people with disability safe. Of the 82% who gave a yes or no response to the first question, 80% did not think a policy stops abuse, assault or neglect from happening and in response to the final question “what do you think would increase the safety of people with disability?”, having more than one support option was the most important (72%) and having money was the least important (39%).

**C2. What do you think would increase the safety of people with disability?**



A final section “Any Other Comments” gave people the opportunity to write in more detail about their experience or to discuss in general the issue of safety for people with disability. A discussion and analysis of these comments and the statistical results is included in the following sections of this report.

**All boxed, italicised quotations in the remaining sections of this report are actual quotations from the investigation responses. Any references to actual places, people, dates and other identifying comments have been changed or removed to protect the identities of those involved.**

## **Discussion**

### **Response Rate and Barriers to Participation**

The response rate<sup>17</sup> to the Community Investigation, which, while relatively low, given the high level of interest generated by the campaign, may have a variety of causes which directly parallel the reasons the participants gave in their responses when asked why they had not reported an incident of suspected abuse, assault or neglect. Past research has connected low reporting rates and the reluctance to report abuse, assault and neglect with the reporting person's fear of retaliation, further victimisation, or intimidation and problems with hard evidence or a failure to investigate and resolve incidents.<sup>18</sup> A recent study in California also comments that most crimes against people with intellectual disabilities tend to go unreported for similar reasons.<sup>19</sup> Studies have further revealed the lack of reliable statistics on the issue of abuse, assault and neglect of people with disabilities.<sup>20</sup>

The statistics on crime in the community reported by the Queensland Police use only age, gender and location as indicators for both offenders and victims of crime. The Annual Report 2003-2004 makes no reference to people with disabilities except in its workforce equal employment policy, though the report discusses "pro-active, problem-oriented policing" and "Responding to our clients" as part of the key activities for the year.<sup>21</sup> Statistics on the number of complaints made to the Australian National Disability Abuse and Neglect Hotline are not available as part of that agency's annual report and despite repeated requests by QPPD for the release of the Queensland statistics we were unable to obtain this data.

---

<sup>17</sup> However, the response rate in this investigation corresponds with general crime statistics for Queensland. The ABS Regional Statistics 2004 for Queensland note that the state population recorded on 30 June 2003 was 3.8 million and the Queensland Police report the number of crimes for the same period, excluding property crimes totalled 159,963, representing 0.4% of the population. The CSTDA NMDS Regional Profile for Queensland records 13,903 service users of CSTDA funded services in the period 1 January – 30 June 2003. In the QPPD Community Investigation, of the 82 people who said they reported an incident, 50 said the incident occurred 2 years ago, in 2003, representing 0.36% of service users.

Sources: [www.abs.gov.au/Ausstats](http://www.abs.gov.au/Ausstats) , [www.disability.qld.gov.au/cstda/data\\_profiles](http://www.disability.qld.gov.au/cstda/data_profiles)  
Queensland Police Service. (2004). *Annual Statistical Review 2003-2004*.

<sup>18</sup> Conway, N.F., Bergin, L., & Thornton, K. (1996)

<sup>19</sup> *Abuse and Neglect of Adults with Developmental Disabilities: a Public Health Priority for the State of California*, (2003)

<sup>20</sup> Chenoweth, L. (1993)

Petersilia, J., Foote, J., & Crowell, N. A. (2001)

Sobsey, R. (1994)

<sup>21</sup> Queensland Police Service. (2004). *Annual Report 2003-2004*

Queensland Police Service. (2004). *Annual Statistical Review 2003-2004*.

There may be a general misunderstanding about what constitutes abusive, negligent or neglectful behaviour which meant people did not participate in the investigation, because they did not think it was relevant in their situation or even recognise that certain incidents constitute abuse, assault and neglect. Even when it was clear that some respondents were very knowledgeable about the service system, there were legitimate reasons for not reporting certain incidents.

*I am an articulate well known person who gets to choose their own staff and shift times and still feel under threat of abuse or misguided practices by my support workers. In fact sometimes I feel the fact that I can speak out can makes me even more vulnerable as I may get branded a trouble-maker and my issues may get taken less seriously (i.e. 'crying wolf') by my service. That is why I pick my arguments carefully - I often will not raise issues until they become major issues because I don't want to be de-legitimised. I have often seen or experienced things that would not constitute direct abuse but are nonetheless highly questionable practices.*

There are many people with disabilities who may find it difficult to distinguish between what is reasonable and abusive treatment; some treatment regimes (chemical restraints, for example) and practices (use of 'time-out' rooms) border on abuse or neglect. They might also fear losing the only person who they see as a friend; sometimes service workers are the only contact people with disabilities have with people who do not have disabilities and they may provide the only avenue to actually doing something outside of an otherwise wasted existence. In these conditions, it is not difficult to see that people may be reluctant to challenge questionable practices as they may be emotionally tied to the person who is abusing them or fear losing opportunities to participation. In addition some people with disabilities may have needed to ask the same service worker to fill in the questionnaire – reluctance to make this request would be understandable.

It is also significant to note that for the most part, these types of incidents occur behind closed doors. Information is either closely-guarded or is only known to the abuser and the abused, and the abused may never disclose or have no-one to disclose to. As was and to some extent still is the case with incidents of sexual or domestic violence or child abuse, the public awareness of the issue is often only by media coverage of isolated incidents and horrifying graphic public statements by courageous victims, families and whistleblowers. Public outrage then leads the push for 'something to be done'. For people with disabilities, however loud the call to the public conscience about abusive or neglectful treatment by the service system, sadly, it seems to reverberate in a vacuum. The relatively low-key media coverage afforded to the Bribie Island case in 2004<sup>22</sup>, while it resulted in a good deal of public outrage, did not even secure the release of the report of the investigation into the facility, let alone effect any real systemic change. Nor did it seek to redress the impact on people with disabilities and their families who were and are severely traumatised by these incidents and for whom justice still remains to be done.

---

<sup>22</sup> *Sunday Mail*, 28/03/2004, *The Courier Mail*, 7/06/2004, 28/08/2004, 1/10/2004.

For many people previous experiences of making complaints or the trauma of past events prevented them from participating in this investigation. This finding raises major questions about the extent of abuse, assault and neglect within disability services which remains unreported and unresolved. Telephone calls on the 1 800 line revealed there were many people who admitted they were unable to re-visit what had been very traumatic and distressing events.

People further said they did not report an incident because they lacked sufficient evidence, feared retaliation, '*have had enough stress*', did not know what to do or did not think anything would be done. These factors also influenced the lower rate of participation in this investigation.

Some people did not participate because they were worried that the identities of those concerned and the particular situation were so specific that even if personal details were removed, they might be further exposed and they feared the consequences of this.

Others speculated on what would be achieved by this investigation. Having been through many avenues of complaint and investigation, these people saw little or no benefit for themselves or their family member in participating in an investigation like this, which was unlikely to lead to a resolution of their particular issue.

One person expressed disagreement with the Community Investigation, saying that they had never had any complaint about service provision. However, with only this one exception, people who contacted QPPD to participate or to comment in general or explain why they would or could not participate in the investigation, said they supported the investigation of this issue and commended the organisation for this initiative.

Further reasons for not reporting an incident or participating in this investigation were revealed when we examined if people felt their issue had been resolved or if any one was treated badly, because they did complain. Nearly three-quarters of those who had reported an incident considered that the issue was not resolved and over half that someone had been treated badly.

*We had to stop a service we desperately needed as I felt the local coordinator/manager didn't believe us*

*I reported abuse but just stuck up for the clients and it got to a stage that I was bullied by my manager and other staff*

*My complaint was not investigated properly and I was sent from Brisbane to [a city in another State]*

## What keeps people safe?

QPPD's position on what keeps people safe is echoed in the answers respondents gave to the question, "What do you think would increase the safety of people with disability?" (C2 in the questionnaire) For most people the most important factors contributing to the safety of people with disabilities were:

- having more than one support option,
- trained staff,
- having an advocate,
- community awareness,
- being better informed,
- being part of community,
- being involved in decisions

and the least important factor was having money.

If we examine the most important factors, it is clear that while people with disability and their families acknowledge that support services provided by well-trained staff is an important and undeniable factor for their well-being, they believe overwhelmingly that the best chances for keeping people safe are found when people are supported to be connected to other people in the community in a range of ordinary ways. Sobsey (1994) notes that we need to do more than just remove people from institutions and relocate them to community-based services; people need to have real contact with their local neighbourhood, real leisure activities, real work opportunities, which occur within ordinary workplaces and real residential options. Only then do people have an opportunity to make friends and develop and grow as individuals. Real interaction with community encourages reciprocity, people become involved in the lives of people with disabilities and their families, friendships can develop, people begin to look after and help each other. Even when abuse, assault and neglect occurs, people saw having relationships as a safeguard to ensuring the issue would be raised and that relationships with others might prevent further incidents. Yet we know that, even with the support of families, friends and advocates, safety is not guaranteed; imagine then what happens without the voices of family, friends and advocates; people with disabilities are much more likely to continue to be abused, assaulted and neglected.

Where individuals have little contact with family, friends or advocates, are in out-of-area placements or receive all their support within a single service, they are isolated from the support and vigilance of others and standards of care receive little monitoring, increasing the risk of abuse and of abuse remaining.<sup>23</sup>

---

<sup>23</sup> White, C., Holland, E., Marsland, D., & Oakes, P. (2003) P7.

*Workers... need skills in how to interact with people with a disability, how to have them involved in activities and be aware of what a community can offer a person so that person's life is fulfilled. Life must be more than shopping and watching endless TV.*

*Services [need workers] that care more about the people with a disability and what is best for them*

While the majority of respondents did not believe a policy alone stops abuse, assault or neglect, the recognition of the increased vulnerability of people with disabilities who use services, led people to express the view that policies are an important element of service provision and that services must operate within a professional framework and be accountable to both the users and the funding body of the service.

*There is no absolutely sure way to prevent abuse and neglect of vulnerable people but increased community awareness and empowering of people with a disability and their families assists to meet this goal. Clear policy statements also send a message to the community*

Respondents wanted services to balance these elements of good service practice alongside individualised service delivery designed to facilitate as ordinary a life as possible for the person within their natural community. O'Brien, O'Brien and Schwartz (1990) noted that it is very difficult to achieve the right balance between protection and neglect

“How do we collectively protect people without patronizing them or destroying their opportunities?”<sup>24</sup>

And that ever tougher regulations and quality assurance systems do not work to build better quality services for people with disabilities and a fundamental flaw in thinking is to forget the humanity of the people for whom the service is provided and that the role of services is a caring one. Westcott (2004) distils this thinking into a very simple phrase “No industry can ever manufacture caring”.<sup>25</sup>

---

<sup>24</sup> O'Brien, J., Lyle O'Brien, C., & Schwartz, D. B. (1990). P9

<sup>25</sup> Westcott, R. (2004).

## Critical Issues

### 1. The extent and nature of abuse, assault and neglect of people with disabilities within disability services

#### A culture of sanctioned abuse, assault and neglect?

The history of violence in the culture of services is well known (Chenoweth, 1993; Sobsey, 1994; White, 2003). It can be argued though that little has been learnt and little has changed. To live in an isolated setting away from family and friends, as many people with disabilities still do in Queensland - in institutions, group homes and other congregated, segregated settings - constitutes an abuse in itself. It was evident from the responses received that the extent of abuse, assault and neglect is a major issue. Over 82% of respondents stated that they had experienced, seen or knew of someone who had experienced abusive treatment and for two-thirds of those, this treatment had occurred in the last two years, in other words, since the introduction of the policy.

The nature of the abuse, assault and neglect of people with disabilities included incidents which constitute non-criminal acts, such as emotional abuse, verbal abuse, instances of neglect and financial abuse and assaults.

#### Therapy – curative or destructive?

Chenoweth (1993) questions whether in fact some service ‘techniques’ or treatments don’t actually teeter on the edge of abuse. She applies the term ‘institutional violence’<sup>26</sup> to this kind of treatment which includes some forms of therapy and medical care, the use of chemical restraints and behaviour management techniques.

*They ... experimented with drugs trying to bring him to submission. They locked him in a small room which was his bedroom for 3 days and had no light, no windows and only a mattress on the floor, a pillow and rug. We were going mad and I had to find a way to get him out of there. I begged them to let him home for a few hours and never let him go back. He was going yellow, a sign his liver was failing from the drugs they were experimenting with. I feel he would have died if I had not got him out of there.*

*Medication is given to residents regularly to sedate them or help them sleep. They have their dinner at 5pm and must be in their room at 7pm. They are expected to stay there until after 6am.*

#### Financial control

It can be argued that the practice of giving a service authority and control over the person’s funding package and other financial supports, such as Centrelink

---

<sup>26</sup> Chenoweth, L. (1993) P37.

payments they may receive, is a form of institutionalised financial abuse. The person with disability or their families often have no control over the way their own money is used or are not provided with proper audited accounts each financial year. In many cases, people are provided only with small amounts of 'pocket money' on a weekly basis and may not even have full access to that.

*The person concerned was victimised and lost funding*

*Workers have talked about my money as if I'm not there (one worker was asked by the coordinator [to] take control of my money). Another time the coordinator took money from my purse to pay for something without asking me first.*

*My family member has an individual package of some \$31,000. In a twelve month period, \$11,383.63 was used for other clients' support. At the end of the financial year, the spreadsheet showed a balance of \$7,565.87. At the beginning of the next financial year the opening balance was \$286.20. These figures are based on an audit of the organisation and no explanation has been received.*

### **Verbal humiliation**

Verbal abuse, while not a criminal act, inflicts enormous damage to self-esteem and confidence and devalues the person in his/her own and other's view significantly.

*"Looks like a tart"*

*Yelling and telling her to 'shut up'.*

*Consumer yelled at by staff for gorging food.*

### **Consequences of emotional and psychological abuse**

The long-term damaging effects of emotional and/or psychological abuse can lead to anxiety or depression and can intensify into mental health issues in someone already fragile. This in turn can develop into self-destructive types of behaviour patterns.

*The time he appeared to suffer terrible self abuse, the organisation tried to say it would have been self inflicted. If this were so, he must have been suffering severe mental trauma.*

### **Criminal behaviour**

Physical assault clearly falls within the range of a criminal act. The DSQ Policy Resource Booklet in its explanation of the term assault uses the

definition from The *Criminal Code Act, 1899*<sup>27</sup>, and goes on to explain the distinction between an 'assault occasioning bodily harm' and 'common assault'

When the injury sustained in an unprovoked attack is minimal, the offence of 'common assault' is judged to have been committed and is regarded as a 'misdemeanour'.

*Consumer hit across face by staff.*

The charge of 'bodily harm' is used when more serious injury or injuries is received by the victim, but from which the victim will recover; then the offender is 'guilty of a crime'.

The investigation revealed that even when people presented substantial physical evidence of possible abuse or assault, they or their families encountered great difficulty in finding out how, where and when this had occurred. In both the following examples, the families were unable to raise any investigation into how the injuries had occurred.

*Child had welt marks (beating with rope) on the back, a bruised coccyx, lineal red marks on the bottom and top left leg thigh area. Child was indicating pain on back and discomfort.*

*On one occasion we found our family member's face and body badly swollen and bruised. We were never able to ascertain in whose care the abuse took place. One service organisation looked after accommodation and another organisation community access.*

The crime of sexual assault is devastating for the victim and is difficult to prove; incidents occur in great secrecy, in out-of-the-way places and at quiet times of the day and night. In addition, it may be very difficult for a person with disability to accuse a service worker of sexual assault, when this might be the very person on whom they depend for all or most of their social interaction and physical functions. They may also be the only person with whom the person with disabilities has **any** kind of social relationship, good or bad, which may mean that they would be unwilling to do anything to lose this. Service organisations may also be unwilling to believe such allegations or provide inappropriate responses.

*I've written about an incident (suspected sexual abuse) at the back of the questionnaire and how badly it was handled and not addressed. So I can't fully answer this question satisfactorily. Incident was totally ignored.*

<sup>27</sup> "A person who strikes, touches, or moves, or otherwise applies force of any kind to, the person of another, either directly or indirectly, without the other person's consent, or with the other person's consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without the other person's consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect the person's purpose, is said to assault that other person and the act is called an 'assault'. *Criminal Code Act, 1899*. Queensland S. 245(1)

In the following example, despite the evidence and repeated attempts of the families to have the incidents investigated, the perpetrators remained in the service for almost two years, before any charges were laid.

*Boys were sodomised and girls raped, others humiliated, beaten, locked in a cage, burnt with cigarettes and hot chillies in mouth.*

### **Neglect and negligence**

O'Brien et al (1990) make a distinction between active and passive hurt. Active hurt is when someone does something to a person which is an assault resulting in injury and passive hurt is when something is not done for a person, neglecting their needs, or when something is done in a negligent manner resulting in harm.

When service workers fail to follow medical instructions, the consequences can be life-threatening. Such failures constitute neglect.

*I had him home for weekend from the service and noticed he was having some petit mal episodes including eye flickering etc on the Sunday. On return to service I told the worker that the specialist had instructed doubling up the epilepsy medication if this occurred and worker could check file re this as I had given them specialist's letter. Obviously no notice was taken as when I rang next morning; worker said there was nothing wrong with him.*

Negligence can lead to instances in which people are abused and assaulted by other people who use the service.

*Consumers assaulted physically/verbally/ sexually by other consumers.*

Negligence can also lead to serious physical injury.

*The negligence of NOT watching him when advised resulted in him having major fits all night and unattended in back room of hostel. Service worker rang me early morning after calling an ambulance when they went in to wake him and found him covered in blood. He had nearly destroyed his tongue etc from seizures. I went straight to the hospital - it was a terrible time - nurse said she had never seen such tongue/mouth injuries except in horrific head injuries from a road accident.*

In many of the above cases, as well as the evidence people submitted being alarming and disturbing, many cases remain unresolved.

*The organisation concerned has not been disciplined despite dozens of other families also reporting cases of abuse and neglect. In fact the service concerned is still being funded and allowed to continue the service where children have been abused by staff which is encouraging history to repeat itself!*

Even in the few instances which indicated there had been resolution, the respondents noted a lack of openness around the issue and unwillingness on the part of the authorities to pursue any disciplinary or criminal charges. Many responses noted secrecy, inadequate or ineffective action and a lack of real commitment to pursuing the matter as hallmarks of their experience.

*Offender sacked. Counselling provided. But nothing was ever made public.*

*They apologised but I believe the documents are still in records, and the apology was in a closed room and not public and not made by the person that had written the report.*

*Staff members were allowed to leave the service with no record of inappropriate behaviour. One staff member got an unfair dismissal payout but no charge for the assault.*

*In general DSQ does not want to know unless the police are called, services have a tendency to "hide" incidents.*

Some people with disabilities and their families whose serious complaints against their service providers were swept under the carpet at all levels of the hierarchy, are so outraged by this response, that they find courage to go public. It is often only when people speak out to the media that such incidents reach the public domain. The media coverage of the abuse, assault and neglect of residents in a facility on Bribie Island has recently revealed the ongoing incidence of abuse, assault and neglect within many services to people with disabilities in Queensland.<sup>28</sup>

---

<sup>28</sup> *Sunday Mail*, 28/03/2004, *The Courier Mail*, 7/06/2004, 28/08/2004, 1/10/2004.

## How does abuse develop?

The petri dish of human service organisations can provide a fertile environment for a culture of abuse to develop. Sobsey (1994) termed this “institutional abuse”, which he defined as not only abuse which occurs in actual institutions, but also in places like group homes and other settings such as day services, schools, even transport services. In such situations, the relationship which exists between the abuser and the abused is largely determined by the service system. In other words the people who work in these services have contact with people with disabilities only for the provision of that service.

Four factors which may lead to the occurrence of institutional abuse are power inequities, collective lack of recognition of the deviancy of such behaviour, the ‘cover-up’ and environmental isolation (Sobsey: 1994).<sup>29</sup>

Some respondents identified these same factors in their own or their family member’s situation.

### 1. Power Inequity

The first factor of institutional abuse - power inequity - can exist on a number of levels within human service organisations. Users of a service and their families may have little or no control over the provision of the service, neither on an actual day-to-day practical level:

*Restriction about when they could go to bed and get up in the morning, having a set menu with no options or flexibility about meal times or meal content and rigid times for meals and other personal activities.*

nor in the wider context of having representation of their interests in the governance of the service:

*Services MUST encourage families to be involved instead of demonising families and overriding their wishes for their family member.*

Service workers identified they had very little control over how the service was provided and if they questioned practices, they were fearful of losing their jobs, having their shifts reduced or bullying and victimisation.

*I had one staff member try to intimidate me by stalking me.*

Left in a position of powerlessness, service workers may direct their anger or frustration towards those with even less power or authority, the users of the service.

---

<sup>29</sup> Sobsey, R. (1994).

*The acting manager of the service verbally abuses staff and the younger people with disabilities who attend the service centre. The Manager is prone to violent, loud temper tantrums, often throws things, thumps the desk or wall and screams abuse. The Manager talks down to the clients, many fear the manager's presence. Many families have left the service - for others who depend on the service this is a difficult decision as there are no other services to support them.*

In many instances, a hierarchy of punitive responses is the result, in which all members are involved. One submission we received, noted that in an investigative report conducted by a Queensland administrative agency, the particular service has:

*An organisational culture that allegedly includes poor attitudes and practices on the part of some, towards the people that it serves - allegedly poor communication by local management with families of people being served, leading to perceptions of abuse of power and a loss of trust in management. This includes perceived threats to security of tenure and/or service - a wide range of concerns about staffing, including allegedly poor recruitment, orientation and training of staff, judgemental attitudes and lack of empathy.*

Another submission noted:

*A culture of punitive behaviour management practices existed for some years... which were often accepted by staff without question.*

In such circumstances in which imbalances of power become the norm, where staff have more power than the users of the service, but are themselves powerless in relation to the management of the organisation, there is a very real threat of abusive behaviour towards the least powerful occurring.

We need to make it clear that powerlessness equals abuse. That information, plus support from someone who cares, plus access to effective methods of recourse are the minimums necessary to safety for people with little power and control. (O'Brien et al, 1990)<sup>30</sup>

## **2. A collective lack of recognition of the deviancy of abuse**

The second factor of institutional abuse - lack of recognition of the deviancy of such behaviour - can emerge as an abusive subculture, in which both workers and the users of the service become tolerant of and reluctant to respond to abusive practices and may even begin to consider it normal practice: abuse, assault and neglect may also become collective, involving more than one victim and more than one perpetrator.

---

<sup>30</sup> O'Brien, J., Lyle O'Brien, C., & Schwartz, D. B. (1990). p27

*Verbal abuse from staff towards clients; Client's clothes thrown in toilet at the service; Staff would egg him on to get them out; Staff screaming at clients... causing distress and anxiety; Worker told to "go out" with clients who had no money; Staff seen at RSL during day without clients; Staff leaving client in "soaking incontinence pads"; Leaving client in "[a quiet] room" for long periods; Client was found [bound and gagged]; The Manager was present and laughed when a worker challenged this; Later staff justified action by saying it was to "keep the person quiet"; However when the authorities got involved, they said "we were wrapping the person up as a present"; Manager suggested client (who was very unsteady on their feet and has epilepsy) be pushed into full size pool; Clients forced to eat off the floor; Staff grabbing people roughly; Hosing a client; Setting off party poppers in a client's ear.*

### 3. The cover-up

Evidence like this also outlines the first level at which the third factor of institutional abuse, the 'cover-up' begins. Unless someone steps forward to challenge such behaviour, it becomes the daily reality and the practice is passed on to new workers, who can also fail to recognise the inherent malpractice which is occurring. Evidence also shows that many workers, who do recognise this as a corruption of the notion of support, tend to leave the service; only the ones, who do not question, stay and the practice becomes self-perpetuating<sup>31</sup>.

*But the abuse continues; many or most of the very skilled staff who have been there for a long time have left the service.*

*Staff were reluctant to make complaints about abuse because of intimidation and harassment by a core group of senior staff*

*Other staff have been sacked (about 12 people over the last 12 months). I remain quiet due to fear of losing my job. I am looking for other work. New, current staff are unskilled as there is no commitment to staff development, very poor manager/staff relationship, very poor family/manager relationships.*

In the case of the Bribie Island investigation mentioned previously, QPPD sought the release of the report into the facility from the Adult Guardian under the *Freedom of Information Act (Qld)*, a request which was denied on the grounds that a police investigation into some of the allegations was ongoing and that a release of the report could prejudice this. QPPD has since discovered that the matters involved in the police investigation are not identified in the report and that names of all persons involved are withheld in the report. This unwillingness to release reports about such serious matters is further evidence of a lack of accountability and transparency and begs the question 'who or what is really being protected?'

<sup>31</sup> White et al (2003). McCartney, J. & Campbell, V.A. (1998).

#### 4. Environmental isolation

The fourth and last factor of institutional abuse, environmental isolation can occur paradoxically within the ordinary arena of everyday life.

Many people no longer live in actual institutions<sup>32</sup> (though many still do) and have been moved into group homes and other community-based living arrangements such as hostels and nursing homes, but they may still remain in environmental dislocation from ordinary life. Often all their social interactions occur alongside, but not actually part of, ordinary community activities and always as part of a distinct group, of which they are the least powerful member. Examples of this include:

- Work environments, in which all the staff, except the management, are people with disabilities, usually receiving significantly less for the work they do than a worker in similar open employment.
- Community access programs, in which people with disabilities 'access the community' often in an easily-identifiable group, accompanied by a number of staff, in activities in which we all engage but which we call 'going shopping', 'going out for coffee' or 'going to the movies'; and
- Adult training centres, where people with disabilities attend during the working week and are taught work and life skills, like cooking, handicraft and computer skills for example by a team of staff and management; however such training centres generally don't result in graduation, with most people with disabilities attending a centre for most of their lives.

Environmental isolation still occurs for some people with disabilities in Queensland in an all-encompassing way, and in ways not dissimilar to the isolation of institutional incarceration.

Some service organisations in Queensland have a whole-of-life approach to the provision of services to people with disabilities.

Services are sometimes located on the outskirts of our town and cities, in the country, in remote regional areas. These services are places in which people with disabilities often conduct all aspects of their lives. Unlike the typical life experience, in which you live in your own home, go to a place of work outside of home, meet friends socially at clubs, cinemas and other public places or visit relatives and friends in their homes, these services provide a place in which people do all of these activities often within the one location and only with the other people who use the service. People with disabilities both live and work here; they engage in social activities here or if they do go elsewhere it is usually as a group. They are rarely or never visited by or able to go and visit family and friends, not because the person, their family and friends do not

---

<sup>32</sup> The Basil Stafford Centre in Wacol for example.

want visits but often because it is too distant from their original home location. And sometimes involvement with family, friends or others, external to the service, is actively discouraged by the service provider.

*A service is moving people with disabilities out of their facilities and into dementia units in aged care facilities. The people are 50 years and under and often moved to wherever a bed can be arranged many kilometres from their own community.*

*My adult, married family member (who lives in another state with own family) was phoned by manager and told that I had lost the plot. "Please give consent for [person with disabilities] to be moved to a different town."*

*Both I and my partner went to service to hand manager a request for an incident report and we were told to leave the property as we were trespassing.*

Such organisations encourage families to virtually hand over their family member into the complete control of their system, often using the 'we know what is best for them and you won't have to worry' hook. They might provide, what one respondent termed 'a cradle to the grave' service in many circumstances, including employment within the same service setting, sometimes of an agricultural or light industrial nature, but always of a financially-viable, income-producing nature for the service organisation. The work is paid, but as mentioned above, the wage level for people with disabilities in such services is much lower than for similar employment in the open workplace. Social contact rarely occurs outside the service setting, though occasionally the community is invited in for an 'open day' or similar event. People might exist in this type of service for most of their lives.

*I have seen so much neglect, abuse and assault within the organisation I am involved with and other disabled people who have no family to support them. People are moved from residential to residential for all sorts of reasons, such as sexual abuse, physical abuse, for extra funding, or simply because the staff "do not like them".*

In isolated services like these, without real contact with family, friends and local community people with disabilities are genuinely segregated and not only cut-off from community, but effectively excised from life. There is also the very real danger that environmental isolation leads to a lack of monitoring and oversight of service organisations, not only by the 'authorities' but more importantly by the community, families, friends, advocates and allies. Without oversight, the culture of abuse can spread rapidly and, if left unchecked, develop into a malignant growth of poor, even negligent or abusive service delivery.

## 2. The emotional, physical and financial costs of abuse, assault and neglect

The ongoing effects of having experienced, heard of or witnessed abuse, assault or neglect are likely to include combinations of emotional and physical trauma and in many cases financial hardship. It is also evident from this investigation that lodging a complaint adds significantly to the emotional, physical and financial costs, which those concerned experience. Sobsey (1994) notes this phenomenon that people who report incidents are further victimised for their action. In its 2003 Annual Report the Complaints Management Quality Committee noted there was a lack of real support offered to complainants.

“The committee was disturbed to note the lack of real support to consumers and family members who raised a complaint. The committee was most concerned this may be a barrier to people actually making, or continuing with, a complaint.”<sup>33</sup>

*Have had enough stress*

There can be additional trauma for those people involved in the reporting of incidents of abuse, assault and neglect which is no longer connected to the actual incidents of abuse, assault and neglect. Respondents noted not only that they felt discredited, intimidated and put-down, but that the process itself had left them further damaged and that little or no support was offered or made available to them through the process.

*I was left with very little or no support from the very organisation that was set up to help people like me. I was sent somewhere I'd never been before. I felt as if "I were left without a feather with which to fly".*

If they did seek emotional support or counselling, this was most likely to be through their own informal networks of family and friends.

If the reporting of incidents can leave people so traumatised and hurt, the likelihood of reporting further incidents is reduced. It requires enormous energy and strength to face and endure a process which, from the outset, you know to be not only unresponsive and unsupportive, but also disbelieving and downright hostile in some cases.

*“What is the use complaining to Caesar about Caesar?”*

Many people expressed a lack of faith in the actual policy, procedures and any subsequent process for complaints management. With no independent, external oversight of the process, a lack of accountability and no recourse to legal action, people saw no point in pursuing the matter.

<sup>33</sup> Complaints Management Quality Committee. (2004). *Annual Report 2003\_P.21*.

*I feel that my information was ignored and that people were not interested. DSQ allowed an internal investigation to be carried out by the service provider. There was no external, independent investigation.*

*There is no point in complaining. I have been very active in my complaint. I have no faith in the complaint system.”*

Most of us would avoid situations which we know from experience have left us scarred, yet many respondents did acknowledge that they would be dogged in their pursuit of any future allegations.

*I would spend the next two years, much emotional energy and stress, money and time doing it all again. I will never give up the fight for my family member's basic rights to be upheld.*

*Not the conventional way that's been proposed through DSQ or Adult Guardian. Instead I would act independently through the normal legal system and obtain counselling and support of my own choice.*

A further consequence of complaining which acted as a significant deterrent to complaints being lodged or pursued was the fear of threats, retaliation, intimidation, further abuse, assault or neglect, loss or reduction of service.

*Daring to complain has intensified the issue*

Westcott (2004) noted that the use of fear and intimidation which was an overriding and terrible feature of human services in earlier centuries continues to be applied in current human service programs.<sup>34</sup>

People with disabilities who use services and/or their families noted the following repercussions, intensifying, instead of, improving a situation. The support they or their family member needed from a service was removed or reduced, people were further victimized or threatened; they or their family member were sometimes ostracized and refused further support in their complaint and they were subjected to vindictive campaigns of intimidation and reprisals

When a family member, friend or advocate reports any suspicions of abuse, assault or neglect, it is often ignored and can result in further abuse, assault or neglect. In addition legitimate contact with the service by the concerned family member is jeopardised.

*Was advised staff could not be sacked because of [law] suits, and pressured to allow those same staff to continue working with my family member.*

In the following example, after a staff member was assaulted, the abuser was instantly removed. However the abusive behaviour by that staff member towards the service user was ignored.

---

<sup>34</sup> Westcott, R. (2004).

*First incident came to a head when the client who had been assaulting my family member for two years assaulted the staff; he was immediately removed. Other abuse such as my family member can tell me, is still continuing, i.e. [particular] staff continuing to assist with personal care against his wishes, waking him up at night. Yelling and telling him to 'shut up'. The [person] involved (the senior support worker) has not spoken to me for about six months, but gets other staff to talk to me instead.*

The person who makes the complaint may be treated with disbelief, hostility and aggression and instead of supporting the person, every effort may be made to intimidate the person into withdrawing the complaint.

*As my child's guardian, I naively assumed that the service would be concerned to hear of my suspicions that my child had suffered sexual abuse whilst in the care of one of their programs. As I stated above I was treated aggressively, literally being interrogated by the manager who tried every way possible to devalue my concerns. The Manager justified this approach by saying 'this is how the police will question you'. This service claims to support the person with the disability and their family, yet at no time was it considered that my suspicions may be correctly placed and that they had any responsibility to be supportive in following this through reasonably.*

Lodging a complaint can lead to emotional blackmail, with threats of withdrawal of service

*Family treated badly for mailing complaints - people listened but nothing came out of the complaints. We as a family have suffered emotional abuse by DSQ and I feel that my family member suffered because as a family we spoke out.*

*My family member was refused service by organisation after they found out I had made a complaint.*

*When the subject was broached with Service Manager we were told very bluntly: If you keep complaining we will refuse to provide further service.*

People are subjected to frustrating techniques and unsubstantiated reasoning, in which no-one will assume responsibility for what has happened.

*Each instance of reporting resulted in buck-passing to another and when questioned resulted in defences such as budget restraints. When suggesting I would go to the particular minister the response became almost threatening.*

Services may try to 'play down' complaints and deny the seriousness of such events.

*Whenever I approach the agency they refuse to accept what I say or trivialise what is going on - my family member has experienced deliberate discrimination by this agency as well as neglect.*

People with disabilities are further victimised by loss of services, lack of appropriate support, the threat of further abuse and retaliatory behaviour.

*I would like to confront the service worker with my family member but am frightened because he is vindictive and may increase his abuse of my [family member when I am not there.*

*I'm not sure if any policy can help me. I have not had help from any department I have approached. I feel most victimized.*

*The service was very narky and made things difficult between my applying for a service transfer and it occurring.*

For some families such pressures left them with nowhere else to go and they removed their family member from the service.

*We had to stop a service we desperately needed as I felt the local coordinator/manager didn't believe us.*

*I didn't feel confident the service believed my concern and so we had to stop our respite with them to protect my child who is non verbal.*

An additional consequence of making a complaint was loss of or damage to the person's reputation. As well as being discredited, services sometimes try to claim that the person is only inflaming the situation by their actions or they try to criticise or condemn the complainant and make damaging claims about their abilities in other areas.

*I felt as if I was a liar and troublemaker.*

*I was labelled naïve and a troublemaker for bringing it (the situation) to many people's notice.*

*The person with a disability was made to feel incompetent.*

*I was made to feel I was wrong. I was then accused of issues of neglecting my child.*

*Don't believe anyone was listening to what was said, as mother's name was discredited.*

*Abusive phone calls. Legal letter to desist discussing these issues with other carers or persons (i.e. threatening letter). Services restricted. Financial and systematic abuse began to occur. An attack on my ability as a parent started to begin and be documented.*

The impact of the incident itself results in trauma. Similarly the impact of the way in which a complaint is handled can have a powerful impact on the person and the families involved. The families are said to become 'secondary

trauma victims' who experience unique as well as similar post-traumatic symptoms to the person who was the actual 'victim'.(Petersilia et al, 2001) <sup>35</sup> These symptoms can include depression, anxiety, anger, loss of self-esteem and the effects can be very long-term. Some respondents expressed overwhelming traumatic reactions to the incident itself and the service response which correspond closely to such post-traumatic stress symptoms.

*It has been a long and distressing time in recording my complaints due to the treatment and intimidation I have suffered over many years. It has been so difficult to record my story and at times I had to stop as I became emotional in recalling the treatment of my family member and this family.*

There is little or no training provided in the fields of psychology, counselling or victim support designed to raise awareness of the impact of violence in the lives of people with disabilities and their families, to develop an understanding of increased vulnerability or to apply appropriate therapy techniques for their post-traumatic stress symptoms. (Voices, 2000) <sup>36</sup>

Service workers who challenge or report abusive behaviour or go so far as to make an official complaint are also subjected to similar repercussions, which often have significant impacts on their lives. Workers also noted that while they were often traumatised by reporting incidents, there were serious implications for those who use the service, the fear of which also meant some workers may not report or challenge incidents:

*I feel one client was targeted because I did stand up for person.*

*Repercussion, threatening phone calls and letter and retaliation. Services were stopped and in other case services cut in half.*

For staff members who complained there were also many consequences as a result of their actions. These included loss of employment, reduction in shifts, intimidation, stalking and in some cases, serious health issues for the person concerned.

DSQ service workers are afforded protection by the Whistleblowers' Protection Act; but a person who works for a DSQ-funded service does not have this protection. In both cases however the whistleblower may be targeted by other staff members for their actions.

*I reported abuse but just stuck up for the clients and it got to a stage that I was bullied by my manager and other staff.*

---

<sup>35</sup> Petersilia, J., Foote, J., & Crowell, N. A. (2001).

<sup>36</sup> *Voices: People with an Intellectual Disability and Victims of Crime. Part A: Preventing Crime, Abuse and Exploitation within Services. Part B: Healing and Moving On.* (2000).

*I was bullied, harassed, intimidated, undermined, and demonised by management for reporting and pursuing the abuse allegations to be fully investigated.*

It is noteworthy that the Public Advocate recently referred to this 'punitive culture' when he said:

It seems that many people and organisations in Queensland experience considerable difficulty in communicating their concerns effectively to those who have it in their power to make things right. ... It might be ... someone who is attempting to advocate for another who they believe is being neglected or abused: as often as not these people have reported to me that they are ignored or stereotyped as troublemakers; to then be marginalised or threatened. This punitive culture extends to how we respond to cases of neglect and abuse when they do come to light.<sup>37</sup>

When workers do follow the procedure for reporting complaints, these may go nowhere with repercussive consequences for all those involved:

*Support staff not allowed to lodge complaints eg with Police, Adult Guardian etc without first lodging an incident report - supervisors don't always take action on these reports which leaves support worker and person being abused etc, with nowhere to go.*

*Sending one staff member out with twelve clients. This happened to [worker] all the time, after he made complaints. It was a punishment for [worker] as well as neglect for the people.*

Some service workers, while they recognise the need to report incidents, believe that it is not their place to actually act on someone's behalf.

*I feel it goes against the actual work I do if I mandatorily (sic) report without this coming from the person I am working with. I will support people to report crimes and encourage them to look at their situation and do so themselves always.*

Self-determination and autonomy may not be paramount in these situations. However, when concepts of self-determination, autonomy and choice are misapplied in situations of potential abuse or neglect and used to justify a failure to report incidents, it can place the person with disabilities in a position of increased risk.

In addition it may be difficult for a person with disability, in particular, intellectual disability to understand the issue of choice and consent in situations where potential abuse can occur. Sobsey, (1994) points out that 'abuse may be the rule rather than the exception and residents might not differentiate between abuse and other aspects of their care'.<sup>38</sup> Decision-

<sup>37</sup> Boardman, I. (2004).

<sup>38</sup> Sobsey, R. (1994). P91.

making capacity is often reduced for people whose lives are largely determined by service provision; they are rarely asked to make a decision or choice as their daily lives are mapped out and directed by others; they cannot choose to stay in bed in the morning or go for a walk when they want. Strict rules and regulations govern the daily cycle. They have little opportunity to exercise their right to make choices or decisions and may never have chosen or decided anything of any consequence or had the opportunity to experience the learning potential of outcomes.

Service workers who participated in the investigation were generally prepared to step forward on behalf of the people they supported, regardless of, or perhaps initially, in ignorance of the consequences for themselves.

*Following workplace policies got me nowhere except a nervous breakdown and being unable to return to work. If I saw abuse again I would still report it but not to management first, Police first.*

In distinct contrast, service organisations who participated in the investigation were more circumspect in their views. More than half said they had never seen or heard of any abuse, assault or neglect of people with disabilities (presumably from within their own service) and offered few comments on how they would respond if they did. Service coordinators and other levels of management within an organisation may not have a real connection with the people who are served by their service. The current emphasis on technocratic managerialism has meant that senior management may neither see the need nor understand the relevance of spending time either with people who use their service or even with service workers. They become so distant from the actual human service provided by their organisation that they experience less concern for the well-being and safety of people with disabilities using the service. In addition, with an increasingly industrialised perspective of human services, in which quality systems, performance indicators and other regulatory mechanisms become the measure of the service provided, many newly-recruited managers are 'content-free' with skills and experience in bureaucratic processes and little knowledge or wisdom about people with disabilities and their families. It is hard to imagine a person-centred delivery of service if you do not know the person nor understand their lived experience.

### 3. The current trends in disability service provision including staff training and work practices.

Nearly 70% of respondents indicated that they saw having more trained staff as a means to increasing the safety of people with disabilities who use DSQ or DSQ-funded services. From the comments people added to this section, it is clear that it is not an increase in the numbers of staff per se which people saw as making a difference, but an increase in training for staff. Many respondents identified the lack of training and poorly- or under-qualified staff as major issues.

*New, current staff are unskilled as there is no commitment to staff development*

Respondents identified the importance of careful selection of staff using criteria designed to choose staff with ethical principles, values and beliefs that recognise and value difference as a potential life force rather than a negative life drain, who welcome, encourage and support the people they serve to develop meaningfully as human beings.

*Most abusers are trained! Certificates mean nothing if the worker doesn't care about people with disabilities and is not interested in supporting people to have a rich life, to grow and learn*

Westcott, (2004) puts this point succinctly: people are being processed in a human service context, rather than cared about in a personal and intimate sense.<sup>39</sup> He further states that human service systems are based on principles of good practice more relevant to industry and manufacturing than to our basic human needs for love, nurturing, acceptance and friendship. The words 'human' or 'people' are glaringly missing in almost all DSQ documents, indeed even the title of the Ministry and the Department itself – Disability Services Queensland - make it abundantly clear where the focus lies. Many respondents recognised this in their comments, stating that they saw the policies and processes as protecting service providers and the service system rather than providing protection to people with disability who use services.

*Most investigations are about risk management to the organisation.*

As already discussed, the lack of any enforcement mechanism in the administrative process is a very real deficiency in this service system. Clearly, any human service system which serves people who are seen to be more vulnerable and therefore more at risk does require appropriate policies, procedures and guidelines. However all of these must be designed to guide service organisations to develop good supervision, monitoring and accountability processes for direct service provision. Service workers not only need these processes to negotiate the complicated mix of the professional and the personal which direct support work entails, but they also need

---

<sup>39</sup> Westcott, R. (2004).

guidance in how to build appropriate relationships with the people they support. Service organisations need to look not only at 'industry qualifications' when employing people; they need to ensure that workers are genuinely open to supporting people and building supportive, friendly and caring relationships without transgressing the boundaries.<sup>40</sup>

The role that good policies, procedures and guidelines assume for the service users is undeniable. People with disabilities who use services have a right to feel protected by a well-designed and implemented service system. But also that they have control and authority over decisions affecting their lives; that they can exercise some natural freedoms and experience the exhilaration of learning through doing something they have never done before, even when this involves risk. This is a delicate balance. But when service provision is dominated by over-regulation and protective measures, the opportunity for personal growth and development for people with disabilities can often be lost. It does not mean that a service would act negligently or ignore its duty of care and allow blatantly dangerous or criminal behaviour which would be injurious to the individual or to others, but it does mean that services recognise the dignity of risk.

### **The dignity of risk and the arc of the pendulum swing between risk and protection.**

Can we protect people from everything in life which is risky? More to the point, do we want to? Isn't risk-taking part of the inherent uncertainty of life? We can take out insurance against risks as a safeguard, but this does not prevent risk.

We all take risks in our lives; developing into adults involves taking risks; as children, it also involves those who care for us, our parents, allowing us to take those risks. We learn, grow and develop from our experiences throughout our lives. We take risks and chances all the time, which shape who we are; and the consequences of those risks and chances, both positive and negative, define how we respond in similar situations. How many times have we said "I won't do that again!" because we know it did not work out the last time we did it? And who hasn't taken calculated risks, knowing that we cannot guarantee the outcome. Every day most of us drive in a vehicle or cross traffic-laden streets, with no guarantee that we won't have an accident. When we go to the beach, we go for a swim – a pleasure we choose, knowing full well that there is no guarantee we will make it back to shore. In fact, we might not dare to engage in some risky activities out of fear, yet we admire and applaud the friend who tells us they intend to learn to sky-dive; their risk-taking we support enthusiastically, though some of us might choose to urge caution too! Risks lead us further in our development of self and inform us – the highs and lows of life determine who we are. We would never expect someone to get behind the wheel of a car without first learning how to drive and the rules of the road. When showing someone how to and when it is appropriate to do something and how that affects the lives of others, we are showing them how to differentiate between responsible and irresponsible behaviour and consider their own actions based on that learning. How can we

---

<sup>40</sup> White et al (2003).

deny that opportunity for personal growth to people with disabilities through complicated risk management strategies, which are designed to prohibit them from all known and possible future risks? Aren't we condemning them to what Goffman (1961) called 'being exiled from living'?<sup>41</sup> in which he describes institutional life as a demoralising experience in which little or nothing about 'how to live life' is learned.

In a seminar on risks and rights, conducted by the Victorian Office of the Public Advocate in 2004, Craig (2004) considered how to enable risk-taking alongside risk management. He suggested that that it was "not so much a case of finding the perfect balance but creating the negotiating space for movement between these competing needs for adventure, excitement and risk up against an enduring need for safety, security and comfort ... The ongoing management of this balance demands a swinging pendulum not a static one"<sup>42</sup>

At this same seminar, it was argued that an ethical service approach needs to be one in which legitimate risk-taking and risk management are equal and competing objectives of service practice. Green (2004) further states that governments have tried to predict and control all forms of risk through rational systems of accountability and control and he questions whether a life in which all risks in life are controlled is preferable to the 'reality of uncertainty' which recognises the unpredictability of the course of human life.<sup>43</sup>

It was recently reported by People with Disabilities (NSW) Inc that some service providers in New South Wales are said to have recently adopted and are enforcing a ban on personal care assistants travelling with 'clients'.<sup>44</sup> The justification for this ban is the service providers' understanding of their obligations under Occupational Health and Safety which, they state, prevents them from delivering personal care services in environments where there has not been a formal assessment of risk. This effectively bans people with disabilities from the normal patterns and rhythms of life in the community as they cannot travel to work, visit friends, go on holiday or choose where they receive services. It is a fundamental human right under the United Nations International Covenant on Civil and Political Rights and ratified by the Australian Government in 1998 to be able to move freely within society.<sup>45</sup>

---

<sup>41</sup> Goffman, E. (1975).

<sup>42</sup> Craig, D. (2004). Action for Community Living. Presentation at Risks and Rights Forum: Office of the Public Advocate, Victoria, 20.10.2004.

<sup>43</sup> Green, D. (2004). *The Risk Society and the Protection of Rights: Implications for an Ethical Practice*. Presentation at Risks and Rights Forum: Office of the Public Advocate, Victoria, 20.10.2004.

<sup>44</sup> PWD e-bulletin, (2005); Issue 20. [www.pwd.org.au/e-bulletin](http://www.pwd.org.au/e-bulletin)

<sup>45</sup> Article 12: *International Covenant on Civil and Political Rights*. (New York, 16 December 1966). Entry into force for Australia (except Article 41): 13, November 1980. Canberra: Commonwealth of Australia. (1998).

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.
2. Everyone shall be free to leave any country, including his own.

#### **4. The effectiveness of the DSQ Policy *Preventing and responding to the abuse, assault and neglect of people with a disability***

The discussion about whether or not legislation and regulations prevent people from doing harmful things to each other or otherwise act as a deterrent has long been underway and both sides of this argument have their fervent supporters. One thing which can be said without much controversy is that bad things continue to happen in society. Legislation is often introduced in response to these actions. Nonetheless we observe increases in criminal statistics which lead to ever more proscriptive measures, tougher regulations and legislation being introduced: yet violent attacks continue to occur, despite the existence of criminal legislation with tough sentencing options for violent crimes. It may be that legislation and policies are doomed from the outset in their intention to prevent, as they operate only as response mechanisms. We have many centuries of knowledge passed down from wise and observant citizens about the capacity of humans to permit and to conduct cruelty towards others and of society's constant vain search for a method of control.

This does not mean that we should have less rather than more legislation, regulations and policies, but that we must recognise they will never prevent 'man's inhumanity to man' – they are a reaction to an undeniable element of the human condition. As White et al (2003) indicates

Much research and policy development has concerned recognition, reporting and responding to incidents of abuse. Policies and guidance for good practice and effective responses are an important development and can play a significant role in prompting interventions to prevent sustained abuse. However, their focus is essentially reactive, offering guidance in responding to abuse which has already been committed and where supporting evidence is available.<sup>46</sup>

The DSQ policy is essentially such a response mechanism. While its stated aims are in 'preventing and responding' to abuse, assault and neglect, it outlines only what to do in response to alleged incidents. It does make some broad statements about services recognising the dignity and value of people with disabilities and respecting the additional vulnerabilities of people in the adoption and implementation of service delivery strategies. However the policy does not offer guidance to services about how to deliver a service within an environment and culture which reflects this values base.

---

3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.

4. No one shall be arbitrarily deprived of the right to enter his own country.

<sup>46</sup> White, C., Holland, E., Marsland, D., & Oakes, P. (2003)

The policy document makes little further reference to either the human, civil or legal rights of the person with disabilities. It documents the response procedures services are expected to adopt when an allegation of abuse, assault or neglect is made and provides examples of procedures. Throughout the procedures and examples, emphasis is on ensuring the rights of the alleged offender are not infringed and upholding their right to natural justice. There is also detailed reference to the obligations of the service to the alleged offender. However there is no reference to any obligation towards upholding the legal rights of the person with a disability. The policy simply outlines how a service should document how to support the subject of the abuse, assault or neglect to access counselling, support and debriefing.

In this investigation, however we discovered that service workers and organisations represented 15% of the total number of respondents who said they had no knowledge of the policy (49%). For these respondents, it would seem to be irrelevant what the policy states about obligations of the service; if workers are ignorant of the policy, they are also ignorant of their obligations in general.

Recognition of the inherent inability of the policy to prevent abuse, assault and neglect is apparent in the responses to the investigation. People acknowledged the necessity of response mechanisms, however when the mechanism is impotent and lacking any real enforcement measures, it is, as a number of respondents noted, 'a toothless tiger'. Sobsey (1994) went further and stated that even when strong policies are created if they are not enforced and unenforceable, the results can be worse than if there were no policy at all and abuse continues unchecked. Respondents too noted the absence of any real enforceability.

*Report it to police first, to make sure it would be followed up, because there might be lots of policies, but still no action. The abuse and neglect still continues but no acknowledgement from DSQ even if you now have policy*

*Policies are often just rhetoric – they don't actually mean anything will change*

Respondents noted that protection and prevention would only occur as a result of a cultural shift in attitude.

*People's values, ethics and attitude do not change because of a piece of paper.*

*Without the will of people to treat other people well, a policy will not achieve anything*

*A policy doesn't change poor culture and attitude within bureaucracy and organisations*

*A policy is a statement of intent and it is the implementation which demonstrates effectiveness. Implementation is dependent on "human beings" and therefore depends on the personal attributes and the individual's beliefs, values, attitudes and their willingness to challenge their "systems" and hierarchy*

QPPD was disturbed by the number of respondents who said that abuse, assault or neglect was ongoing. Given the very public, well-documented and detailed history of instances of abuse, assault and neglect within Queensland services<sup>47</sup>, it was expected that we would receive evidence from people which referred to events from a time when this particular DSQ policy was not in place. We were surprised and shocked therefore to receive so much evidence of recent (i.e. within the last two to five years) and ongoing incidents.

By comparing our evidence with the statistics on complaints in recent annual reports from various Queensland administrative agencies, we can see that our investigation reflected a true picture of the ongoing nature of abuse, assault and neglect.

In 2003 one in five Australians (20%) had a reported disability and Queensland reported the highest rate of reported disability (23%).<sup>48</sup> In 2003-2004 The Adult Guardian noted that 67 matters investigated were about physical abuse/neglect and 10 were about sexual abuse/assault. In 2002-2003 the Adult Guardian conducted 83 investigations into physical abuse/neglect and 10 into sexual assault.<sup>49</sup> In the same year the DSQ Complaints Management Quality Committee, noted 53 reported incidents of abuse, assault and neglect and a further 19 of misconduct and in 2003, 32 reported incidents of abuse, assault and neglect and a further 12 of misconduct. They further noted that 79 complaints investigated in 2003 and 33 in 2002 contravened the Queensland Disability Service Standard 9, "Protection of legal and human rights and freedom from abuse and neglect".<sup>50</sup>

---

<sup>47</sup> A few examples of inquiries conducted since 1991 include the Criminal Justice Commission Inquiry into the Basil Stafford Centre, The Forde Inquiry and inquiries into the Cootharinga Society, Maryborough Disabled Person's Ward and Ward 10B, Townsville General Hospital.

<sup>48</sup> Australian Bureau of Statistics. (2004). *Disability, Ageing and Carers, Australia: Summary of Findings (2004)*. [www.abs.gov.au](http://www.abs.gov.au), accessed 17/01/2005.

<sup>49</sup> Office of the Adult Guardian. (2004) *Annual Report 2003-2004*.  
Office of the Adult Guardian. (2003) *Annual Report 2002-2003*.

<sup>50</sup> Complaints Management Quality Committee. (2004). *Annual Report 2003*.  
Complaints Management Quality Committee. (2003). *Annual Report 2002*.

## **5. How complaints are handled by DSQ and**

## **6. The level of satisfaction of complainants about the resolution or otherwise of their complaint**

QPPD received information during its investigation into how the complaints mechanism operates from sources very close to the Complaints Management System (CMS), which reveals a fundamental lack of accountability and independence in its operation.

The respondent said that in some complaints, the CMS was “pretty powerless’ with the process being driven by other departmental offices. Powerlessness of the complaints management system however is an in-built feature given that the *Disability Services Act 1992(Qld)* itself does not recognise the Complaints Management System nor does it require services to comply with it; instead DSQ requires services to implement the CMS as a condition of funding. Similarly the Act contains no provision for the investigation of complaints for issues such as allegations of abuse or neglect, relying again on implementation by service providers through the mechanism of funding agreement conditions.

It was further stated by this respondent that the CMS did try to refer some complaints to external authorities, who sometimes refused to take on such referrals or instigate any further action in these matters. In addition it was claimed that issues of official misconduct were taken very seriously whereas complaint issues ‘were not going anywhere’, with outcomes of complaints at very low levels. Staffing issues were also identified, in particular high staff turnover and high stress-related leave rates accounting for many delays in investigating complaints.

The community investigation revealed a high level of dissatisfaction with the management of complaints and the official complaints process.

*Nothing happened - “nobody is listening to us”.*

The reality for most respondents was that their lodging of a complaint of abuse, assault or neglect led nowhere.

*I met with DSQ twice, they said they would address my complaint with my service provider - nothing happened to my knowledge*

The outcome of complaints which do proceed through to investigation is very low. The DSQ Complaints Management Quality Committee in a discussion paper from October 2004 notes this fact:

The Committee has noted complaints in which there was inadequate closure and failure to follow-up on important issues. The implication of this was that complainants were dissatisfied with the outcomes and the issues had not necessarily been resolved. In some cases, the

Committee observed that the whole process had appeared to be 'a waste of time' for all concerned. Nothing was different or better.<sup>51</sup>

It should be noted that this refers to complaints which are investigated by the DSQ Complaints Management System. The majority of complaints do not get this far in the process. Any report to DSQ Complaints is initially treated as a "concern" and very few are actually afforded the status of a complaint.

Most reports of abuse, assault and neglect are made in good faith by people with a disability, their family or service staff to the service agency involved in supporting the person. Indeed, the process described in the policy itself (Policy S1.10.) requires an initial report to be made internally. Major concerns for the respondents were:

- the length of time taken for the service to respond to a complaint or refer it to another agency,
- the lack of information about progress,
- and the failure to implement changes in service delivery in response to complaints.

*There is no evidence that any complaint system is effective from my point of view. Further, the response time where a complaint has been made, in my experience, can be several months after placing the complaint before any investigation occurs if it does.*

*Meetings were held with me and senior staff. I was told things would improve. DSQ advised me issues would be resolved. I wrote letters to management, met with more senior staff but nothing changed.*

Most respondents stated that their complaint was ignored or not treated seriously. Of overwhelming concern regarding this lack of action is the possibility of continued abuse, assault or neglect of the person. When services fail to recognise, challenge and respond appropriately to poor or abusive staff practices and attitudes, signals are sent to the people who use the service, the people who work in the service and to the wider community that such behaviour and treatment of vulnerable people is tolerated.

*My complaints did not stop bad things from happening in 3 different DSQ-funded services*

*Nothing has happened after repeated contacts to DSQ by myself, advocate, solicitor, National Abuse Hotline.*

<sup>51</sup> Complaints Management Quality Committee. (2004). *Discussion – Accessibility of the Disability Services Queensland Complaints Management System*. Brisbane: Disability Services Queensland. P.6

During the course of the Community Investigation, QPPD attempted on numerous occasions to obtain statistics on the number of complaints from Queensland made to the Australian National Disability Abuse and Neglect Hotline. These requests were rejected without giving any reason by the Commonwealth Department for Families and Community Services. QPPD is aware that the Hotline is expected to refer complaints on to the DSQ Complaints Management System if they consider the complaint falls within the Queensland jurisdiction and that in the two and half years, in which the Hotline has been operational, no referral protocols have been developed between the Hotline and the DSQ Complaints Management System.

The complicated process of lodging a complaint was not facilitated by the service organisations or DSQ in its management of complaints. Indeed respondents noted there was not only a failure to provide information and assistance to complainants in the lodging of complaints, but a denial of the right of the complainant to access incident reports or to be provided with information on the progress of the complaint through the system.

*[Service] refuses to speak to us even through dispute resolution; won't give incident report. DSQ say they have no enforceable authority over the [service] to demand an incident report of what happened to our [family member].*

*We were constantly following up waiting & waiting on answers to many of our unanswered questions.*

The progress of any complaint was also hampered by the lack of any standardised protocols for handling complaints. One complaint can pass through many hands or experience lengthy delays in the course of its investigation and every handover or delay has the potential to dilute, divert or distort the original version of events.

*After I submitted my complaint I was contacted by [person] from DSQ who assisted me in redoing my complaint. When it was finished after 6 months I felt as if it had been completely changed around. I insisted that my original statement be used as it stated exactly what had happened when I went to visit my [family member].*

Many respondents noted the denial of their right to independent advocacy assistance. Independent advocacy assistance, support and help are vital in any complaints process involving individuals and organisations. While the complaints process is not designed as an adversarial process, the experiences described in this investigation suggest that the process is sometimes distorted. In addition, no organisation can claim that an in-house advocate is independent; workers cannot be independent of the service in which they are employed, no matter how genuine their commitment to the person, there is an inherent conflict of interest, which destroys independence. A genuine response from workers would acknowledge this conflict of interest and seek to secure an independent source of advocacy assistance for the person.

*I felt my issues with the service worker weren't taken seriously by DSQ case worker or service manager. When I requested a meeting with service I was not allowed to have an advocate of my choosing accompanying me*

Many respondents advised they experienced lengthy delays before receiving any response to their complaint and that outcomes were often unacceptable. Complaints were either not resolved at all or the resolution was an inappropriate or ineffective response, sometimes exposing already vulnerable people with disabilities to further abuse, assault or neglect. Alleged perpetrators might be moved to other service facilities, exposing people within those services to potential abuse, assault and neglect.

*DSQ took 18 months to respond to official complaint.*

*Those concerned were simply placed elsewhere with other vulnerable clients.*

*Abuser (was fearful and ashamed when) threatened with policy action. Eventually relocated to a 'more suitable' residential.*

For many respondents the breaches of confidentiality and privacy which accompanied their complaints had significant consequences. While every effort is made to protect the alleged perpetrator, it seems no effort is made to protect the abused or neglected person with disabilities, their family members and service workers who stand alongside them.

*Confidentiality is breached so the person has a reputation in the community.*

*I am sure I was blacklisted by the local services because I had the "hide to complain.*

*I was assured complete confidentiality but 2 days after being interviewed by DSQ personnel I was phoned by a member of the community and asked if I had made a complaint.*

In addition to handling individual complaints, the purpose of a complaints management system is also to effect systemic change and improve service provision. Without effective, open and accountable complaints management, service delivery remains static and flawed. Changes in service delivery and practice can only occur with due recognition of what can go wrong.

QPPD noted a strong focus by DSQ on their introduction of new strategies and mechanisms, such as the Disability Sector Quality System in 2004 and further review and consultations in relation to the *Disability Services Act 1992*. Any new options developed in these processes will have an impact upon the current systems, including any protective mechanisms, such as the abuse, assault and neglect policy and the Complaints Management System.

The DSQ policy on abuse, assault and neglect has been in operation since February 2002; however the deficiencies of the *Disability Services Act 1992* to provide protection to people with disabilities within services from abuse,

assault and neglect were known when the Legislative Reform Project began and probably before that. These deficiencies included the lack of safeguards and/or protective measures provided by the Act for people with a disability to prevent abuse or neglect of persons receiving services.

There are no statutory requirements for internal complaints mechanisms or provisions which empower DSQ to investigate serious complaints. The Act does not provide DSQ with any investigative powers nor does it provide for any sanctions to be applied to organisations that fail to take adequate precautions to prevent abuse and neglect of people receiving a service.<sup>52</sup>

It seems evident that there will be changes to the existing measures as a result of the review. The Minister even acknowledges this in a recent letter.

DSQ has a number of other strategies to improve responses to the prevention and reporting of abuse and neglect, including implementation of the Disability Sector Quality System and the *Critical Incident Reporting Framework*. Furthermore DSQ is also developing options to improve the protective mechanisms for people with a disability through the government's commitment to review the *Disability Services Act 1992*.<sup>53</sup>

Why then is the current review of the DSA occurring after all these other measures have been introduced? Surely legislative reform precedes implementation of administrative processes?

### **Complaints-handling by external agencies**

Respondents indicated they were prepared to report incidents to such external agencies as the Adult Guardian or the Office of the Public Advocate. However they noted a lack of responsiveness at this level. Yet it must be noted that the power to investigate complaints is 'discretionary' for the Adult Guardian and the role of the Public Advocate is to 'promote the protection of adults from abuse' and to provide 'systemic advocacy on behalf of adults with a decision-making disability' with no specific power to investigate complaints.

While there is evidence that these administrative bodies do push the boundaries of their powers in some instances, there was the perception of an ineffective and unresponsive administrative system of complaints for many respondents.

*The office of the Adult Guardian is a mannequin in the hoodwinking shop front window*

The Adult Guardian's Annual Report 2003-2004 identifies a number of pressures on the functioning of the Office; increased workload, including further development of a client register database and the drafting of policies

<sup>52</sup>Disability Services Queensland. (2003). *Legislative Reform Project: Review of the Disability Services Act 1992(Qld)*, *Guide to the Review of the DSA*. Brisbane: Queensland Government.

<sup>53</sup> Minister Pitt in a letter to the Hon. Mrs Julie Attwood MP dated 21. Dec 2004.

and procedures, insufficient funding and the absence of a permanent Deputy Adult Guardian for most of the year. Some of these pressures were relieved by the allocation of senior staff to address these issues. A Senior Investigations Officer was re-assigned temporarily to develop written policies and the Adult Guardian herself took a 'major role in the development of the database, due to the absence of a permanent Deputy Adult Guardian and the operational pressures on other managers which have meant that senior management was too thin on the ground to allocate anyone else to the project'.<sup>54</sup>

While it could be acknowledged that these operational developments may contribute to a more effective and timely response process in the future, it must be of little comfort to those people whose complaints took eighteen months to investigate or who are still waiting for a response, let alone a resolution to their complaint, to know that their complaint languished during the course of these developments.

The DSQ policy itself states that all agencies must stipulate in their response procedure that 'any report, allegation or suspicion of abuse, assault or neglect will be immediately reported to the police'<sup>55</sup> though this clearly does not happen in all situations.

*The process doesn't work. Staff are too scared to report and often do it anonymously. "The messenger is shot."*

One third of all respondents who reported an incident went to the Police. Only two said that the issue was resolved by the police and neither of those respondents took their complaint through any administrative process. The remaining two-thirds of those who reported to the Police had also lodged complaints with DSQ, their service provider, their doctor, the Adult Guardian, the Office of the Public Advocate, the National Abuse Hotline and advocacy groups without any resolution.

Relevant external authorities may unwisely assume that allegations of abuse, assault and neglect are the subject of internal investigation and that the service system is the first stage of many in a complaints process. Often this first stage remains the only stage in complaint investigation as services may be unwilling or sometimes actively discourage attempts to pursue any complaint outside of the service. Many staff members believe or learn in induction processes, that their duty, in these instances, is only to report any suspicions to the service manager or board of management. The outcomes of such reports are seldom learnt.

---

<sup>54</sup> Office of the Adult Guardian. (2004) *Annual Report 2003-2004*. Brisbane: Queensland Government. P.3.

<sup>55</sup> Disability Services Queensland. (2002). *Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability; Policy and Resource Booklet*. Brisbane: Queensland Government. P.7.

*Support staff not allowed to lodge complaints eg with Police, Adult Guardian etc without first lodging an incident report - supervisors don't always take action on these reports which leaves support worker and person being abused etc, with nowhere to go.*

The disadvantage of people with disabilities in the criminal justice system of Queensland is acknowledged.<sup>56</sup> Of all social institutions, the criminal justice system has been one of the slowest in its response to attempt to create a system in which people with disabilities receive equal and fair treatment. It has been said that the criminal justice system is one of the last frontiers of integration for people with disabilities.<sup>57</sup> Respondents to the investigation noted significant problems when they did try to access justice for themselves or their family member.

At all levels the criminal justice system displays a lack of awareness of appropriate interview techniques in allegations which involve people with intellectual disability, mental health issues or communication difficulties and a lack of understanding about the impact of disability and service provision in the incidence of abuse, assault and neglect and in any subsequent judicial process.

*I have great concerns about how the interview was conducted. I also have concerns about staff qualifications to interview children with severe physical disability, intellectual impairment and speech impairment.*

*My family member was badly abused in a facility and when this was reported to the police the detective investigating was very off-hand, slightly perplexed and unbelieving of a person who could only talk with her finger. She has no speech and uses facilitated communication.*

The criminal justice system is inflexible and fails to make reasonable adjustments to enable allegations to be investigated when the victim is unable to pursue the charges themselves.

*I have reported this problem to police (they could not help because in reports of sexual assault the victim has to do the reporting). He cannot talk, read or write.*

*We found, on the two occasions that we reported to the police our concerns, they were not interested when they found our family member was incapable of making a statement herself.*

Even in cases in which substantial documented evidence is submitted, the judicial system remains unresponsive and inflexible, resulting in the dismissal

---

<sup>56</sup> Office of the Public Advocate. (2004). *Annual Report 2003-04*. Brisbane: Queensland Government. P.41.

<sup>57</sup> Luckasson, R. cited in Petersilia, J., Foote, J., & Crowell, N. A. (2001).

of cases in which the guilt of the accused is hard to deny and the further damage to the victims hard to ignore.

*The court system was dismissive of person with disability's capacity to be a reliable witness. A Queensland Commission was bureaucratic and kept passing the buck. Again was dismissive of person's capacity to be a reliable complainant, despite physical evidence of assault and abuse.*

*One person with an acquired brain injury was raped and the man charged and brought to court. He was acquitted because the person was an 'unreliable witness' and there were so many men who had access to her...*

Layers and layers of injustice are applied in the resolution of complaints which should leave us all outraged. People with disabilities, their families, advocates and allies struggle to achieve even a dignified and appropriate response let alone the justice of an outcome to their complaint or, at the very least, recognition of the pain and suffering of abuse, assault and neglect by either the 'special' disability system which claims to provide support and protection or the criminal justice system.

## 7. Other Service Systems

While this investigation set out to uncover abuse, assault and neglect of people within DSQ services, some information received related to other government service systems. It would be negligent not to acknowledge the significance of evidence relating to similar issues in other areas of government service provision. QPPD therefore considers it is legitimate to discuss this evidence in this report.

The effects of disability are experienced in all aspects of the lives of people with disabilities and their families, not only in the way disability services are delivered. It affects all areas of life; employment, accommodation, health, education, social, environment, justice, welfare. These are all areas of life for which governments have developed administrative departments to oversee and regulate civil society. Any response to problems within one arm of government should be provided within consistent definitions of overarching concepts, principles and values to guide all areas of government in the development of a common, holistic framework.

Many people with disabilities use other services in addition to or instead of DSQ services. Indeed many people with disabilities are living in hostels and nursing homes because of the failure of the Queensland Government to provide appropriate accommodation options to large numbers of people with disabilities. People with mental illness frequently live in boarding houses and hostels and many people with disabilities are in prisons. Many children with disabilities attend special schools, special education units or mainstream schools and adults with disabilities access TAFE and other tertiary educational services. The delivery of services to these groups of people may fall outside the remit of DSQ, but the Queensland Government has a duty of care towards all people with disabilities, who are using other service systems. Often however, the response to complaints of a systemic nature only results in intra-departmental initiatives and offers no inter-service remedy to a systemic issue. In a recent edition of *Education Views*, Education Queensland's Director-General noted the introduction of a comprehensive range of measures to respond to assault and neglect in schools. He outlined the legal responsibilities of school staff members:

..any staff member who is aware, or suspects, that a student at their school has been sexually abused by another employee [is required] to report the case to their supervisor who must then notify police.<sup>58</sup>

This process is certainly similar to the DSQ complaints process and will no doubt be equally as ineffective. The Director-General noted too that an inquiry found that 'abuse thrives most actively in closed environments where there is little scrutiny' and where the interests of the most powerful group are placed before those of the least powerful.

---

<sup>58</sup> Education Queensland. (2005). Safety of children our priority: *Education Views*. Brisbane: Queensland Government.

Yet DSQ still provides funding to a number of very large disability service organisations operating services which are effectively a whole-of-life solution, often in isolated and large settings throughout Queensland. In such closed environments, where any internal investigation of incidents lacks independent oversight and external scrutiny and monitoring is non-existent, there is every opportunity for abuse, assault and neglect to occur. Abuse will continue to occur in these settings in complete disregard of the DSQ policy.

This is a widespread issue of concern, not just in Australia but world-wide and even when a region, a state or district or even a country implements legislation, policies, strategies, they will not stop the abuse, assault and neglect of people with disabilities outside of that jurisdiction.

## 8. Developing Strategies

Respondents were asked to consider what might keep people safe. While there were inevitably suggestions about more stringent security screening of staff, blue cards, enforcement measures and accountability, these were balanced by many opinions about encouraging services to change the environment or culture.

*A policy doesn't change poor culture and attitude within bureaucracy and organisations. It is what organisations do, not what they say they do.*

*A policy is a statement of intent and it is the implementation which demonstrates effectiveness. Implementation is dependent on "human beings" and therefore depends on the personal attributes and the individual's beliefs, values, attitudes and their willingness to challenge their "systems" and hierarchy.*

Many respondents recognised that little had been learnt from history. The lessons of even the recent past on attitudes and beliefs about people with disabilities or the way people with disabilities are treated are ignored.

*I am truly wondering what has changed in terms of abuse against disabled people over a lifetime. Education of the general public has to start at pre school level and be ongoing,*

The insular and opaque nature of many services was cause for deep concern, not only because it sometimes was seen to facilitate bad practice leading to abuse, assault and neglect, but because the protective layer of secrecy was impenetrable to scrutiny and community involvement. Many respondents noted that service provision needs to open up, to be part of the ordinary fabric of society, not independent of society, but interdependent, reflecting the natural condition of community life.

*Service is a "cradle to grave" service and it doesn't work. There is no independence. If there is conflict between the residential and the day service – the same Manager is in charge of both. Use the community more. [...] Places where the whole community goes and other people are looking on. Why can't we think beyond the box?*

Without insight by the community into the current reality of life conditions of people with disability, there can be no real understanding or commitment to change or improvement.

Many people do not recognise abuse, assault or neglect and even when people do, they are often so 'grateful' to receive any service at all, they do not feel they have a right to complain.

People noted that connections to community, awareness of the issues of abuse, assault and neglect, training and education for people with disabilities,

families and communities to enable recognition and increase awareness of what constitutes abuse, assault and neglect were essential elements in the development of good strategies for protection for people with disabilities.

*Bringing it out in the open and get people to talk about it. Educate and empower people with disability about what abuse is and support them to speak out about their experience in a safe way and mentor people to take control of their own lives. For people living in closed systems - open them!!! Make them be places where concerned citizens regularly visit them and have a vested interest in ensuring that nobody forgets these people and they come to no harm and if they do come to harm someone will stand by them and ensure justice.*

**Key Findings and Conclusion**

The key findings of the QPPD Community Investigation are

1. People with disabilities still experience abuse, assault and neglect within disability services. The extent of abuse, assault and neglect has not diminished in any significant way, nor has the introduction of the policy had an effect of any consequence.
2. The nature of abuse, assault and neglect that people continue to experience ranges from life-threatening, cruel, inhuman and degrading to disrespectful and disdainful neglect.
3. The consequences of the abuse, assault and neglect people have experienced are long-term and devastating for people with disabilities, their families, friends, allies and advocates.
4. Current trends and practices of disability service provision do not reflect the knowledge gained from evidence about ongoing abuse, assault and neglect and the consequences.
5. DSQ introduces strategies and mechanisms, conducts reviews and implements new systems in splendid isolation, resulting in a constant 'tweaking' of the system and with no consideration of the impact of such constant revision on the people who are served by the system.
6. The DSQ Policy is revealed to be ineffective in preventing abuse, assault and neglect. It operates as a response mechanism at best and a diversion from the truth at worst.
7. The DSQ Complaints Management System (CMS) is unable to handle complaints of this nature. Delays in process expose people to further risk and resolution of complaints is unsatisfactory; the CMS cannot deliver justice for people with disabilities or protect complainants.
8. The judicial system is unresponsive and inflexible in its approach to cases which reach the courts.
9. The Queensland Government has not adopted a whole-of life approach to the issue of abuse, assault and neglect and as a consequence there is little cross-service collaboration to address the issues.
10. People with disabilities and their families and when appropriate, their friends and allies are denied significant decision-making opportunities and their wishes and needs are often ignored, overridden or discounted.

This community investigation has exposed unsettling and disturbing evidence that people with disabilities who use DSQ-direct or funded services remain at risk of ongoing abuse, assault and neglect within those services. It has revealed that the response of the service system falls far short of acceptable. At times people are exposed to further risk of abuse, assault or neglect and causing significant further damage to people with disabilities, their families, friends and allies. Our investigation has exposed a lack of faith in the technocratic, industrial-style responses of policies, procedures and quality systems to an essentially human condition. The investigation has uncovered the injustice of the justice system for people with disabilities. And it has confirmed a belief about our shared humanity; its revelations about the way the needs of those of us who are more vulnerable are ignored, repressed and denied are stark and indefensible.

QPPD believes this is not what citizens should expect from a civil society. We expect to be treated fairly and well, to be allowed to develop and grow in a safe environment, to be cared for and nurtured when we are vulnerable and to experience friendship and love. We also expect to contribute in a civil society, treating others well and with fairness, providing opportunities and encouraging others to learn and grow, to protect and care for others and to give friendship and love to others. This is no utopian expectation, simply a way to live a full life.

"We learn, when we respect the dignity of the people, that they cannot be denied the elementary right to participate fully in the solutions to their own problems. Self respect arises only out of people who play an active role in solving their own crisis and who are not helpless, passive, puppet-like recipients of private or public services. To give people help, while denying them a significant part in the action, contributes nothing to the development of the individual. In the deepest sense, it is not giving but taking - taking their dignity. Denial of the opportunity for participation is the denial of human dignity and democracy. It will not work."<sup>59</sup>

Saul D Alinsky

---

<sup>59</sup> Alinsky, S. D. (1971). *Rules for Radicals*, New York: Random House.

## **Recommendations**

The evidence in this report demands attention. QPPD noted that in a letter written by the Minister, the Hon. Mr Warren Pitt in response to an enquiry from local member, the Hon. Mrs Julie Attwood, MP, about the QPPD Community Investigation, he assured Mrs Attwood that any suggestions from QPPD as a result of this investigation would be considered.

Suggestions from QPPD arising from responses to the questionnaire will be considered in conjunction with any future review of the DSQ's *Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability Policy*, the review of the *Disability Services Act 1992*, and implementation of the Disability Sector Quality System.<sup>60</sup>

We offer these suggestions from our investigation for the consideration of the Minister on behalf of all those who participated in the investigation and in recognition of the countless others whose daily lives have been and are perhaps still lived in fear.

There is a need to acknowledge that people with disabilities have been subjected to violent and inhumane treatment for a very long time. The "special" reporting system represented by DSQ policy and in particular, the DSQ policy *Preventing and Responding to the Abuse, Assault and Neglect of People with Disability* is not providing real protection.

As fellow human beings we are obliged to acknowledge this and create the conditions for a paradigm shift to occur. People with disabilities must have the same right to achieve justice, without fear of rejection and without being further victimised. People with disabilities will have more chance of being supported to have a safe and good life when all of society recognises and supports this.

We recommend to DSQ the following suggestions for law and policy reform. And we recommend the following to each and every one of us to reflect on our personal response.

People with disabilities who use services will be safer when:

1. People with disabilities choose where and with whom they live.
2. People with disabilities choose who supports them.
3. People with disabilities choose their own source of independent advocacy and support.
4. Training is provided to people with disabilities and their families on their rights and responsibilities as employers and board members.

---

<sup>60</sup> Ministerial letter to the Hon. Mrs Julie Attwood MP, dated 21. Dec 2004.

5. Services conduct pre and in-service training to management and support workers in human rights, ethics, and values.
6. Services ensure management personnel are fully-trained in all aspects of service provision and conduct regular support work as part of their management role.
7. All services, but in particular those with segregated and/or congregated settings, are supported to move to individualised, person-centred responses.
8. People with disabilities, families, friends and advocates have full and equal representation on the boards of services.
9. Services are open to monitoring by family, friends and advocates on an ongoing basis.
10. A review of the roles and powers of the Office of the Adult Guardian, the Community Visitor Scheme and the Office of the Public Advocate is conducted.
11. Service agencies, of all types and however funded, Government, private or non-funded, must be accountable to an independent agency with full jurisdiction to apply necessary penalties.
12. Quality Standards are applicable to all other Queensland Government Departments involved in providing services to people with disabilities.
13. The *Disability Services Act* is amended to recognise the authority of the DSQ Complaints Management System.
14. The DSQ Complaints Management System has powers to investigate all service complaints other than those of abuse, assault and neglect.
15. *The Whistleblowers Act* is amended to include protection for non-DSQ staff.
16. An independent human rights commission must be set up to oversee all human service agencies and support services.
17. The investigation of allegations of abuse, assault and neglect to be conducted by an independent body which is part of the criminal justice system, with full powers of criminal enforcement, and separate from the DSQ Complaints Management system.
18. The scope of the *Queensland Criminal Code* is extended to allow third parties to press charges of abuse, assault or neglect on behalf of a person with disabilities who is unable to communicate.

19. Training is conducted in appropriate interview and response techniques for police, courts and others involved in the criminal justice system.
20. Training in prevention awareness and personal safety education is provided for people with disabilities.
21. Mandatory tertiary training for counsellors, psychologists and other therapeutic professions to develop an understanding and awareness of the impact of disability.

**APPENDICES****Appendix A - Outline of the key elements of the policy**

The policy and its accompanying resource booklet carry an opening statement from the then Minister for Disability Services, Judy Spence, in which she states that the policy was developed:

- To establish standard practice across all services operated or funded by DSQ.
- To reinforce the Queensland Government's commitment to providing safer communities and better quality services to people with a disability and their families
- To provide a set of core policy principles, procedures and 'guides' to assist service providers to develop procedures to prevent and respond to the abuse, assault and neglect of people with disability and
- The resource booklet is provided to further assist service providers to identify abuse, assault and neglect.

The introduction identifies some key issues and the scope of the policy:

- People with a disability are "silent victims' of many forms of abuse, including neglect and criminal assault by carers.
- "The abuse, assault and neglect of people with a disability in any form will not be tolerated in any service funded or directly provided by DSQ"
- The issue of abuse, assault and neglect will be confronted through four mechanisms:
  - DSQ Strategic Plan 2000-2005, In particular, Strategic Direction 7: Safeguards and Advocacy and Strategic Direction 4: improving quality of services
  - Quality Framework and Disability Service Standards: mechanism to ensure meaningful participation of people with a disability and their families in the improvement of service quality<sup>61</sup>

---

<sup>61</sup> Disability Sector Quality System was introduced in 2004. All services are required to adopt this system, which aims to provide:

- a basis for being accountable for funding
- consistency in quality service delivery across the state
- consistency in quality of service across different service types
- external validation of how the service is run

A set of ten standards, The Disability Service Standards, was introduced with the Quality System, which:

- arise from the *Disability Services Act* (1992)

- Policy and procedures for complaints regarding DSQ services and funded services
- Service agreements to ensure that agencies comply and implement policies
- Policy applies to all services funded or directly provided by DSQ and includes services which support children, young people and adults with a disability.
- People with impaired capacity are further protected through the *Powers of Attorney Act 1998* and *Guardianship and Administration Act 2000*. The role of the Adult Guardian in this regard includes providing protection from abuse, exploitation and neglect and involves investigation of allegations, providing advocacy and legal representation for the person with impaired capacity.
- In matters of abuse, assault and neglect, service providers are encouraged to 'seek advice' from Adult Guardian.
- Policy and its procedures are a mandatory requirement of conditions for funding. All service agreements must include a condition to comply with this policy and any existing or future organisational policies and procedures must be consistent with this policy.
- Complaints resolution process is through the 'Policy and Procedures for Complaints regarding DSQ Services' and/or 'Policy and Procedures for Complaints regarding funded Services'. (These policies also cover other types of complaints and disputes, such as complaints about level or type of service provided or inadequate funding levels.)

The policy contains twenty statements, outlining the obligations and responsibilities of service providers to respond, report and document incidents and to provide information, support and referral to those concerned.

- All service personnel (including management and volunteers) have a 'duty of care' to report all suspicions or allegations of incidents.
- Process for recording of incidents

- 
- reflect the values and underpinning principles of service delivery
  - apply irrespective of service type, location or size
  - are relevant irrespective of relationship to the service (service user, family member, board member, staff or management).

Disability Service Standard 7: Complaints and Disputes and Disability Service Standard 9: Protection of legal and human rights and freedom from abuse, are of particular relevance to the Community investigation.

All service organisations are required to be certified to comply with the Quality System and the Standards in order to continue to receive DSQ Funding.

- To the service (initial report)
- If the person is unsatisfied or unable to refer a matter to the service, then they may refer to other external agencies (including Adult Guardian, Office of the Public Advocate, National Disability Service Abuse and Neglect Hotline or DSQ) or authority (Queensland Police, Crime and Misconduct Commission)
- The person may also make a Complaint to DSQ using 'DSQ Policy and Procedures for Complaints regarding DSQ Services' and/or 'DSQ Policy and Procedures for Complaints regarding Funded Services'.
- Any allegation in which official misconduct (only applicable to staff of DSQ, however), is suspected must be reported to the Misconduct Prevention Branch
- All allegations of abuse, assault or neglect will be reported to the Queensland Police or an external organisation by the agency. However, if the person chooses not to pursue the matter within the criminal justice system, the organisation must ensure the person has been supported to make this decision (through an advocate or the Adult Guardian).

The Policy then lists a set of procedures, which all agencies must include in their documented response procedures.

- **Any report, allegation or suspicion of abuse, assault or neglect will be immediately reported to police** (QPPD emphasis)
- The agency must assist the person to all appropriate support services and if person is under 18, the family or guardian or if the person is in a care service, the Department of Families, must be notified in a timely manner. If the person is over 18 and has a guardian, the guardian must be notified in a timely manner – other relevant people, including family may be informed if person consents.
- Outline the process and timeline
- Ensure detailed accurate documentation and storage of same
- Protect privacy and confidentiality
- Ensure the person making the complaint does not experience retaliatory action and treat all allegations with sensitivity
- However only DSQ staff are subject to the *Whistleblowers Protection Act 1994*

- Ensure the legal rights of the offender are not infringed (DSQ services can consult the Misconduct Prevention Branch, funded agencies can consult the Director of Public Prosecutions) and any police investigation must not be compromised
- Provide information on all of the above to all users of the service, including families, staff and board members.

The procedures then list 7 examples of situations to guide services on how to write procedures to meet the requirements of the policy. Only one 3.7 Example: Support and debriefing, documents what support the service is to offer the person subjected to abuse, assault or neglect to access counselling, support and debriefing; all other examples document supporting the alleged offender and ensuring their rights are upheld. In 3.1 Example: What to do when an allegation of abuse, assault or neglect is made, this includes keeping details of allegations from the alleged offender and other staff until offender charged.

A separate Resource Booklet accompanies the policy and procedures and contains key indicators, examples and reporting options.

- The indicators of abuse, assault and neglect which are included are only examples and not an exhaustive list.
- Perpetrators can be very good at hiding their actions
- The two basic rules for natural justice must be followed;
  - Hearing rule: The person has a chance to put his/her point of view before any action is taken and
  - Rule against bias: a decision-maker must be impartial
- Services must operate with reasonable duty of care and that a higher standard of reasonable care is assumed, if the law regards the person as vulnerable, which includes people with disability.
- Services have vicarious liability for actions by its personnel in the course of provision of service,
- And if they negligently employ someone with a criminal history they are directly liable.

The resolution of complaints of abuse, assault or neglect is through the Complaints Management System

Appendix B - QPPD Community Investigation Questionnaire

# QUESTIONNAIRE

**IMPORTANT INFORMATION ABOUT FILLING IN THIS FORM.**

**Please write your responses to the questions so that individuals or organisations are not identified.**

*While all questionnaires will be regarded as confidential and all information will be securely stored to prevent unauthorised access, if we are made aware of the details of an incident which might be a criminal act, we may be obliged to disclose this information to the relevant authorities.*

**Information about you (please tick box)**

<input type="checkbox"/>	Person with disability	<input type="checkbox"/>	Friend	<p><b>POSTCODE</b></p> <input style="width: 100px; height: 20px;" type="text"/>
<input type="checkbox"/>	Family Member	<input type="checkbox"/>	Service Worker	
<input type="checkbox"/>	Community Member	<input type="checkbox"/>	Service Organisation	
<input type="checkbox"/>	Advocate			
<input type="checkbox"/>	Other (Please identify) _____			

**Q1. Do you, someone you know or work with receive any disability support from DSQ, a DSQ-funded service or a community-based disability organisation?**

<input type="checkbox"/>	<b>YES</b>
<input type="checkbox"/>	<b>NO</b>
<input type="checkbox"/>	<b>Don't know</b>

**? Q1 Note to Q1. Answer yes if:**

- Someone comes to your home to help you with one or a few daily tasks and this person is paid or
- You attend a respite service, day centre, community access, employment service, including workshops, or
- You receive a grant or funding package or
- You live in a group home

**A. Awareness of the DSQ Policy**

In this section we want to find out if the community knows that there is a DSQ policy called "Preventing and Responding to the abuse, assault and neglect of people with a disability".

**A1. Are you aware of the DSQ policy 'Preventing and responding to the abuse, assault and neglect of people with disability'? (Please tick box)**

<input type="checkbox"/>	<b>YES</b> (go to A2)
<input type="checkbox"/>	<b>NO</b> (go to Section B)
<input type="checkbox"/>	<b>Don't know</b> (go to Section B)

**? A1 Note to A1.**  
If you have heard or read about this policy, please answer yes to this question even though you may not understand what the policy is for.

**A2. If yes:**

**How did you become aware of this policy ?** *(please tick one or more boxes)*

<input type="checkbox"/> DSQ	<input type="checkbox"/> Family
<input type="checkbox"/> Service	<input type="checkbox"/> Friend
<input type="checkbox"/> Made Complaint	<input type="checkbox"/> Advocate
<input type="checkbox"/> Other (please specify) _____	

**? A2** **Note to A2.**  
Please tell us how you found out about the policy and if you have seen the policy, resource booklet or pamphlet. We want to find out if people get a copy because they ask for it or because DSQ gives a copy to anyone who receives a service. We also want to find out if DSQ provides copies to services to give out and if services inform workers about the policy.

**Have you seen a copy of the policy and resource booklet?** *(please tick box)*

YES       NO

**Have you seen a copy of the pamphlet?** *(please tick box)*

YES       NO

**How did you get the policy document or pamphlet?** *(please tick one or more boxes)*

<input type="checkbox"/> DSQ	<input type="checkbox"/> Asked for a copy	<input type="checkbox"/> Advocate
<input type="checkbox"/> Service	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Made Complaint	<input type="checkbox"/> Other (please specify) _____	

**A3. Do you understand what this policy is for?** *(please tick box)*

YES  
 NO  
 Unsure

**? A3** **Note to A3.**  
If you know about the policy or have read it, we want to know if you are sure what to do if you want to report an incident. We want to know also if you understand the process as it is outlined in the policy documents.

**A4. Have you used the policy or did knowing about the policy help you to:** *(please tick one or more boxes)*

**? A4** **Note to A4.**  
Please tell us here if you reported an incident or made a complaint. You may tick one or more boxes.

<input type="checkbox"/> Make a complaint	<input type="checkbox"/> Stop bad things continuing to happen
<input type="checkbox"/> Get information	<input type="checkbox"/> Train staff
<input type="checkbox"/> Inform family or friend	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Improve service practice	_____
<input type="checkbox"/> Prevent bad things from happening	_____

**B. Responding to abuse, assault and neglect**

**B1. Have you seen or experienced abuse or assault?**

YES     NO     Don't Know

**B2. Have you seen or experienced neglect?**

YES     NO     Don't Know

**B3. When did this/these incidents actually happen?**

Ongoing     0-2 years ago     2-5 years ago  
 5-10 years ago     More than 10 years ago

**B4. If you answered yes to B1, 2 or 3, did you report this incident?**

YES     NO     Don't Know

**B5. If no, why not? (please tick one or more boxes)**

<input type="checkbox"/> Fear of retaliation	<input type="checkbox"/> Advised not to
<input type="checkbox"/> Lack of evidence	<input type="checkbox"/> Did not know what to do
<input type="checkbox"/> Didn't know enough	<input type="checkbox"/> Didn't realise it was abuse, assault or neglect
<input type="checkbox"/> Other (please specify) _____	

**B6. If yes, who did you report this to? (please tick one or more boxes)**

<input type="checkbox"/> Adult Guardian	<input type="checkbox"/> Co-worker
<input type="checkbox"/> Advocacy Group	<input type="checkbox"/> Support Worker
<input type="checkbox"/> Office of the Public Advocate	<input type="checkbox"/> Doctor
<input type="checkbox"/> National Abuse Hotline	<input type="checkbox"/> Police
<input type="checkbox"/> Family	<input type="checkbox"/> DSQ
<input type="checkbox"/> Friend	<input type="checkbox"/> Service Manager
<input type="checkbox"/> Other (please specify) _____	

? B1 **Note to B1.**

**Abuse** means that someone has done, threatened to do or said bad things to you or someone you know, even when you have shown them you do not want them to or told them not to and even if that person is someone you like. The things they might do are kicking, hitting, shouting, swearing, calling you names, laughing at you, touching you in a sexual way, leaving you in dirty or wet clothes, not giving you food or drink, not keeping you or your home clean, locking you in a room or dark place, ignoring you when you need or want something, stealing your money or your things, using your money to buy things for themselves or not letting you have your own money or things, not taking you to the doctor or not giving you your medicine or by giving you food or drink in a way which hurts or makes you sick.

**Assault** means that someone has done, threatened to do or said bad things to you or someone you know, even when you have shown them you do not want them to or told them not to and even if that person is someone you like. The things they might do are kicking, hitting, touching you in a sexual way or hurting you with objects, such as cigarettes, sticks, ropes, chains.

? B2 **Note to B2.**

**Neglect** means that someone has not done something for you or someone you know when you wanted or needed them to. This could mean that they have left you in dirty or wet clothes, not given you food or drink, not kept you or your home clean, left you alone in a room, dark place or car for a long time, ignored you when you have asked for, or needed something, not taken you to a doctor when you have hurt yourself or not given you the proper medicines. It can also mean someone has given you food or drinks too quickly, too hot or too cold or in a way which hurts you or makes you sick.

**B7. Please tell us more about what happened when you reported the incident?**  
*(please use a separate sheet if needed)*

---

---

---

---

---

---

---

---

**B8. Do you feel this issue was resolved?**  
*(please tick box)*

YES

NO

Don't Know

**WHY OR WHY NOT?**

---

---

---

---

---

---

---

---

---

---

---

---

**B9. Was anybody treated badly because you told someone about the incident?** *(please tick box)*

YES

NO

Don't Know

**Tell us what happened to you or the person concerned.**

---

---

---

---

---

---

---

---

---

---

---

---



**C. Prevention (In this section, please tell us what you think would help to make people with disability safe from abuse, assault and neglect).**

**C1. Do you think a policy stops abuse, assault and neglect from happening?** *(please tick box)*

YES

NO

**If YES: how? If NO: why not?**

---

---

---

---

---

---

---

---

---

---

**C2. What do you think would increase the safety of people with disability?** *(Please tick one or more boxes)*

<input type="checkbox"/> Trained staff	<input type="checkbox"/> Living near family
<input type="checkbox"/> Being better informed	<input type="checkbox"/> Having money
<input type="checkbox"/> Being part of the community	<input type="checkbox"/> Having more than one support option
<input type="checkbox"/> Choosing where and who you live with	<input type="checkbox"/> Doing something meaningful (job/volunteer)
<input type="checkbox"/> Being involved in decisions	<input type="checkbox"/> Having an advocate
<input type="checkbox"/> Having personal unpaid relationships	<input type="checkbox"/> Greater community awareness
<input type="checkbox"/> Other (please specify) _____	

---

---

---

---

---

---

---

---

---

---



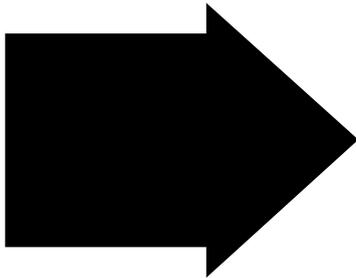
**You have finished filling in the questionnaire.**

**Thank you for taking part in our investigation.**

**If you would like to know more about the investigation, please remember to send in the GREEN optional reply form in a separate reply-paid envelope.**

**If you do not wish to take part in any further stages of this work, then please submit this questionnaire only in a reply-paid envelope.**

**If you change your mind you can at any time send us your details by post.**



Please return this questionnaire in the reply paid envelope provided by 31st January 2005 to:

**QPPD,  
PO Box 470,  
Paddington Q 4064**

***We take this opportunity to assure you that all information given to QPPD in this questionnaire is treated as confidential and that no information which might identify you or your family will be used in the final report.***

Queensland Parents for People with a Disability Inc

# COMMUNITY INVESTIGATION

into  
THE ABUSE, ASSAULT AND NEGLECT  
of  
PEOPLE WITH A DISABILITY  
RECEIVING SERVICES PROVIDED OR FUNDED BY  
DISABILITY SERVICES QUEENSLAND (DSQ)

## INFORMATION BOOKLET AND QUESTIONNAIRE



*The information we gather will be used to review the extent and nature of abuse, assault and neglect of people with disabilities within disability services, the emotional, physical and financial costs of such treatment and current trends in disability services including staff training and work practices. The investigation will also seek to measure the effectiveness of the Disability Services Queensland (DSQ) policy **'Preventing and responding to the abuse, assault and neglect of people with a disability'** to protect people with disabilities from abuse, assault and neglect. A final report on the findings from this investigation will be released at the completion of the project.*

*QPPD vigorously defends justice and rights for people with disabilities by exposing exclusionary practices, speaking out against injustices and promoting people with disabilities as respected, valued and participating members of society.*

Inside this **BLUE** information booklet is a pull-out questionnaire on **WHITE** paper.

You can fill this in if you

- A) are a person with disability receiving services
- B) are a family member, friend, concerned community member or advocate of a person with disability
- C) work with DSQ or an organisation which provides support to people with disability
- D) work for a person with a disability in a support role

Please fill in the optional reply form on **GREEN** paper if you want to contribute further or get more information from QPPD.

### **PRIVACY AND CONFIDENTIALITY**

*The information we gather will be used to review the extent and nature of abuse, assault and neglect of people with disabilities within disability services, the emotional, physical and financial costs of such treatment and current trends in disability services including staff training and work practices. The investigation will also seek to measure the effectiveness of the Disability Services Queensland (DSQ) policy **'Preventing and responding to the abuse, assault and neglect of people with a disability'** to protect people with disabilities from abuse, assault and neglect. A final report on the findings from this investigation will be released at the completion of the project.*

**Please write your responses to the questions so that individuals or organisations are not identified.** While all questionnaires will be regarded as confidential and all information will be securely stored to prevent unauthorised access, if we are made aware of the details of an incident which might be a criminal act, we may be obliged to disclose this information to the relevant authorities.

*Any identifying information you send on the optional reply form should be sent in a separate reply-paid envelope and will be stored separately and securely. QPPD will respect your personal details and will not divulge any identifying information to third parties unless you give permission for this to happen. The report will be written in such a way that no individuals or organisations will be able to be identified.*

---

## ABOUT THE COMMUNITY INVESTIGATION

### **Why is QPPD doing a Community Investigation?**

QPPD is a systems advocacy organisation which influences political, social and service systems about important issues in the lives of people with disabilities and their families.

In the course of our work we regularly hear stories of abuse, assault and neglect of people with disabilities. We feel it is important to gain a better picture of how much this is happening, where this is happening and what happens to people when it happens. QPPD wants to understand if the policy that DSQ has to keep people safe actually works.

### **What will QPPD do with the information from this Questionnaire?**

We will write a report based on this research and all the information we receive in the questionnaire. The report will help QPPD identify harmful ways people with disabilities, who receive services provided or funded by DSQ, are treated in Queensland. It will also be used by QPPD to advocate for better, fairer and safer supports and services. The report will be distributed to all the people who contribute to it as well as politicians, the department, services and other interested members of the community.

### **What should people do if they are experiencing abuse, assault or neglect right now?**

It is important that instances of abuse, assault and neglect are reported to the police immediately. Like any other members of the community people with disabilities are entitled to protection and assistance to stay safe.

### **Where can people go for help, support or advice if they have experienced abuse, assault or neglect in the past and it still troubles them?**

QPPD understands that this questionnaire may remind some people of some bad things that have happened to them or someone they love or have worked with. It is important to remember that QPPD is a systems advocacy organisation and we do not do individual advocacy for people. QPPD is not able to offer counselling to people who are still suffering from past abuse, assault or neglect. If you need someone to talk to about a past incident of abuse, assault or neglect, a list of agencies is in this booklet.

We apologise to people who may be disturbed by memories and feelings triggered by filling in this questionnaire. We hope that this investigation will help to stop people having bad things happen to them in the future.

---

**The DSQ policy describes abuse, assault and neglect as follows:**

**Physical abuse:** non-accidental actions causing injuries, such as bruising, lacerations or welts, burns, fractures or dislocations; threats of violence; refusing consumers of a service food because they have not done what they were asked to do; hitting, smacking, biting, shaking or kicking; pulling arms, hair or ears; bending back fingers or bending an arm up behind the back; placing hot substances in the mouth for swearing; leaving consumers in clothing or bedding that has been soiled; physically restraining a consumer of a service which is not justified, authorised or excused by law; inappropriate use of medication including the unauthorised use of medication as a chemical restraint.

**Psychological/emotional abuse:** humiliating consumers of a service for losing control of their bladder or bowels; shouting orders to consumers of a service; using humiliating names when speaking to consumers of a service; treating adult consumers of a service as children; humiliation, emotional blackmail, blaming, swearing, intimidation, name calling or isolation from friends and relatives; the use of social isolation (ignoring consumers of a service); staff locking consumers of a service in their bedroom; using other consumers of a service to provide physical control over another consumer of a service; harassing consumers of a service to eat food they don't want to eat (or which is contrary to their cultural or religious beliefs).

**Sexual abuse:** the infliction of sexual assault, sexual harassment and all forms of illegal sexual activity such as molestation, rape and carnal knowledge.

**Financial abuse:** denying consumers of a service access to or control over their money and personal finances; taking money or other property of consumers of a service without their consent (which is likely to also constitute a criminal offence) or where their consent is fraudulently obtained; misappropriation of money, valuables or property; changes to wills or other legal documents, by coercion, misrepresentation or where consent for changes was fraudulently obtained; denying the consumer access to information or documentation concerning their personal finances or individualised funding package; personal use of a consumer's telephone by staff which is not recorded or reimbursed, leaving the consumer to pay the cost of the calls; staff borrowing client's possessions even for a brief period, eg CDs, lawn mowers etc; staff purchasing client's possessions at grossly below the real and accepted value of the item; staff using client's vehicle for their own purposes

**Neglect:** staff assisting consumers of a service to eat and drink in an incorrect or hurried and rushed manner, causing physical discomfort, illness, injury or resulting in or contributing to death; failure to provide consumers of a service adequate food, shelter, clothing or basic personal health care; staff giving one consumer of a service another consumer of a service's medication because it is similar; staff giving over the counter medication to a consumer of a service without first checking with the consumer's doctor for appropriateness or any potential harmful side effects; staff continue to administer medication to a consumer of a service after the use by date has expired; staff not utilising a consumer's communication devices to allow the expression of needs, choices or preferences; failure of staff to recognise or acknowledge non-verbal messages conveyed by consumers of a service who have limited communication abilities; staff leaving consumers of a service alone in a vehicle for extended periods; staff not obtaining or seeking the appropriate medical, specialist, therapy or other allied health support for a consumer based on the identified individual need; staff not ensuring that a consumer has access to regular medical support including assessments for medication blood levels, blood pressure, diet and nutrition or access to regular health screening tests.

---

If you have not heard of the *Disability Services Queensland (DSQ) policy* '**Preventing and responding to the abuse, assault and neglect of people with a disability**' or if you know there is a policy but have not seen a copy, you can get a copy of the policy document by writing or phoning:

**DSQ Central Office**

Tel: 1 800 177 120

**DIAL**

Tel: 1800 177 120

**Central Queensland/Wide Bay**

(Mackay Whitsunday and Bowen, Rockhampton to Gladstone & Longreach, Wide Bay and Burnett)  
Tel: (07) 4932 1671

**Ipswich/South West Queensland**

(Ipswich, Boonah and Laidley plus Toowoomba and far South West)  
Tel: (07) 3280 1872

**North Coast**

(Caboolture Redcliffe, Pine Rivers, Kilcoy plus Sunshine Coast including Cooloola)  
Tel: (07) 5490 1080

**North Queensland and Remote Region**

(Cairns and surrounds plus Townsville and surrounds)  
Tel: (07) 4727 0666

**South Coast**

(Gold Coast, Redlands plus Logan and Beaudesert)  
Tel: (07) 3287 0742

**Brisbane**

Tel: (07) 3109 7007

Or you can download a copy from the DSQ website at:  
<http://www.disability.qld.gov.au/publications/abusepolicy/policy.cfm>



## **USEFUL TELEPHONE NUMBERS**

*If you want to make a complaint about abuse, assault or neglect, you can call:*

<b>Queensland Police</b>	Call your local police station as listed in your telephone directory
<b>Australian National Disability Abuse and Neglect Hotline</b>	<p><b>1 800 880 052</b>  <b>1 800 555 677 (NRS)</b>  <b>131 450 (TIS)</b></p> <p>An Australia-wide telephone hotline for reporting abuse and neglect of people with disabilities using government funded services. Allegations are referred to the appropriate authority for investigation.</p>
<b>Disability Services Queensland (DSQ)</b>	<p><b>1 800 177 120</b>  <b>(07) 3224 8021</b>  <b>(TTY)</b></p> <p>DSQ has policies and procedures for dealing with complaints about disability services. All disability services and their staff must comply with the policies and procedures.</p>
<b>Crimestoppers</b>	<p><b>1 800 333 000</b></p> <p>Crime Stoppers is a telephone hotline for members of the community to provide anonymous information about criminal activity. This information is electronically sent to the police establishment nearest to where the crime is occurring for investigation.</p>
<b>Queensland Crime and Misconduct Commission (CMC)</b>	<p><b>(07) 3360 6060</b></p> <p>The Queensland CMC investigates complaints of official misconduct involving staff of DSQ services.</p>

## USEFUL TELEPHONE NUMBERS

*If you need someone to talk to about an incident of abuse, assault or neglect, the following agencies might be able to assist:*

<b>Salvo Care Line</b>	<b>1300 36 36 22</b>	Telephone counsellors are available 24 hours a day for people who need to talk through a crisis or difficulty
<b>Lifeline</b>	<b>13 11 14</b>	
<b>Centacare</b>	<b>3266 7688</b>	Personal counselling. Contact Centacare direct, no referral is necessary
<b>Bravehearts</b>	<b>3290 4474</b>	Provides comprehensive counselling for child and adult survivors of child sexual assault
<b>Child Abuse Prevention Services</b>	<b>1800 688 009</b>	Counselling and on going support for the victims of child sexual abuse and their families. 24-hour crisis telephone support.
<b>Domestic Violence Resource Centre</b>	<b>3217 2544</b>	Offer counselling and support to women and children and a court support service across all of Qld.
<b>Sexual Assault Helpline</b>	<b>1800 010 120</b> <b>1800 003 989</b>	A statewide 24-hour telephone service (TTY).
<b>Elder Abuse Prevention Hotline</b>	<b>1300 651 192</b>	A state-wide telephone information, support and referral service for anyone experiencing or witnessing the abuse of an older person.
<b>Legal Aid Queensland</b>	<b>1300 651 188</b>	Legal Aid Queensland provides legal assistance to financially and socially disadvantaged Queenslanders.
<b>Health Rights Commission</b>	<b>1800 077 308</b>	Provide an independent and impartial avenue for resolving health care complaints.

---

To download a copy of this questionnaire in PDF format,  
please visit QPPD's website

**[www.qppd.org](http://www.qppd.org)**

Please use the reply paid envelopes to return this questionnaire and the  
optional reply form by

**31st January 2005**

If you need assistance to fill in the questionnaire, more time, information  
or more copies, please phone

**1 800 195 622**  
(freecall)

---

---

**Queensland Parents for People with a Disability Inc**

---

**OPTIONAL RETURN FORM**

QPPD thanks you for taking the time to participate in this investigation and filling in this questionnaire. We appreciate that you have taken the time to contribute to our work. We will be gathering more information on this issue around the State early in 2005.

If you would like to take part in future QPPD work about this issue, please tick YES .

YES       NO

**Information about you** (please tick box)

<input type="checkbox"/> Person with disability	<input type="checkbox"/> Friend	<input type="checkbox"/> Advocate
<input type="checkbox"/> Family Member	<input type="checkbox"/> Service Worker	<input type="checkbox"/> Other (Please identify)
<input type="checkbox"/> Community Member	<input type="checkbox"/> Service Organisation	_____

**Information about QPPD:** we will need to contact you

Would you like a copy of the final report?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like more information about QPPD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like to go on QPPD's mailing list?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like to link with someone from QPPD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you have ticked 'yes' to any of the questions above, please fill in your details below, as we will send you more information about QPPD's work and/or contact you about being involved in further work in this issue.

We take this opportunity to assure you again that all information given to QPPD in this form and questionnaire is treated as confidential and that no information which might identify you or your family will be used in the final report.

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_  
Tel: \_\_\_\_\_ Email: \_\_\_\_\_

Please return this optional reply form in the reply paid envelope to:

**QPPD, PO Box 470, Paddington Q 4064**

---

**COMMUNITY INVESTIGATION into THE ABUSE, ASSAULT AND NEGLECT of  
PEOPLE WITH A DISABILITY receiving services provided or funded by  
DISABILITY SERVICES QUEENSLAND (DSQ) (2004)**

---

## **References and Further Reading**

*Abuse and Neglect of Adults with Developmental Disabilities: a Public Health Priority for the State of California*, (2003). A report of Protections and Advocacy Inc, State Council on Developmental Disabilities, USC University Affiliated Program, The Tarjan Center for Developmental Disabilities. California: UCLA.

Alinsky, S. D. (1971). *Rules for Radicals*, New York: Random House.

Australian Bureau of Statistics. Source: [www.abs.gov.au/Ausstats](http://www.abs.gov.au/Ausstats)

Australian Bureau of Statistics. ABS Regional Statistics 2004. Source: [www.abs.gov.au/Ausstats](http://www.abs.gov.au/Ausstats)

Australian Bureau of Statistics. (2004). *Disability, Ageing and Carers, Australia: Summary of Findings (2004)*. [www.abs.gov.au](http://www.abs.gov.au), accessed 17/01/2005.

Australian Institute of Health and Welfare Source: [www.aihw.gov.au/disability/csda\\_public/index.html](http://www.aihw.gov.au/disability/csda_public/index.html)

Baladerian, N. (1985). *Overview of Abuse of People with Developmental Disabilities*. Orange County: AAMR Conference.

Boardman, I. (2004). *Doing advocacy: Dissent, dissonance or dilly-dally?* Keynote address: Brisbane: Uniting Care Conference 2004.

Chenoweth, L. (1993). The Mask of Benevolence: Cultures of Violence and People with Disabilities. *Journal of Australian Studies*, 43, 36-44.

Chenoweth, L. (2001). Unpacking and Exploring Protection. *Children and Domestic Violence: Still Walking on Eggshells*, 12, 28-31.

Chenoweth, L. (2002). Children with Disabilities: What Evidence Do We Have for Better Practice? ACWA Conference Paper.

Complaints Management Quality Committee. (2004). *Annual Report 2003*. The State of Queensland: Disability Services Queensland.

Complaints Management Quality Committee. (2003). *Annual Report 2002*. The State of Queensland: Disability Services Queensland.

Complaints Management Quality Committee. (2004). *Discussion – Accessibility of the Disability Services Queensland Complaints Management System*. Brisbane: Disability Services Queensland.

Conway, N.F., Bergin, L., & Thornton, K. (1996) *Abuse and Adults with Intellectual Disability Living in Residential Services*. Canberra: NCID & ASSID.

Craig, D. (2004). Action for Community Living. Presentation at Risks and Rights Forum: Office of the Public Advocate, Victoria, 20.10.2004.

*Crime in the Community* (2004). Canberra: House of Representatives Standing Committee on Legal and Constitutional Affairs.

*Criminal Code Act, 1899 Reprint No. 4P* (2005). Brisbane: Queensland Government.

Criminal Justice Commission (1995). *Report on An Inquiry Conducted by the Honourable D.G. Stewart into Allegations of Official Misconduct at the Basil Stafford Centre*. Brisbane: Criminal Justice Commission.

---

Criminal Justice Commission (2000). *The Basil Stafford Centre Inquiry Report: Review of the Implementation of the Recommendations*. Brisbane: Criminal Justice Commission.

Disability Services Queensland. (2003). *Legislative Reform Project: Review of the Disability Services Act 1992(Qld), Guide to the Review of the DSA*. Brisbane: Queensland Government.

Disability Services Queensland. (2002). *Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability; Policy and Resource Booklet*. Brisbane: Queensland Government.

Disability Services Queensland. Source: [www.disability.qld.gov.au/publications/abusepolicy](http://www.disability.qld.gov.au/publications/abusepolicy)  
[www.disability.qld.gov.au/complaints/complaints\\_brochure.pdf](http://www.disability.qld.gov.au/complaints/complaints_brochure.pdf)

Disability Services Queensland (2005). *CSTDA NMDS Regional Profile – Queensland 1 January – 30 June 2003*. [www.disability.qld.gov.au/cstda/data\\_profiles](http://www.disability.qld.gov.au/cstda/data_profiles)

Education Queensland. (2005). *Safety of children our priority: Education Views*. Brisbane: Queensland Government.

Goffman, E. (1975). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Harmondsworth: Pelican. (Originally published 1961).

Green, D. (2004). *The Risk Society and the Protection of Rights: Implications for an Ethical Practice*. Presentation at Risks and Rights Forum: Office of the Public Advocate, Victoria 2004.

*International Covenant on Civil and Political Rights*. (New York, 16 December 1966). (1998) Entry into force for Australia (except Article 41): 13, November 1980. Canberra: Commonwealth of Australia.

Jahoda, A. & Markova, I. (2004). Coping with Social Stigma: People With Intellectual Disabilities Moving From Institutions and Family Home. *Journal of Intellectual Disability Research*, 48, 8, 719-729.

McCartney, J.R. & Campbell V.A. (1998). Confirmed Abuse Cases in Public Residential Facilities for People with Mental Retardation: A Multi-State Study. *Mental Retardation* 36, 6 465-73.

Nosek, M.A. & Howland, C.A. (1998). Abuse and Women with Disabilities. *Violence Against Women*. Minnesota: Minnesota Center Against Violence and Abuse.

O'Brien, J., Lyle O'Brien, C., & Schwartz, D. B. (1990). *What Can we Count on to Keep People Safe? Perspectives on creating effective safeguards for people with developmental disabilities from discussions in the Pennsylvania Developmental Disabilities Planning Council Annual Retreat*. Georgia, USA.

Office of the Adult Guardian (2003). *Annual Report 2002-2003*. Brisbane: Queensland Government.

Office of the Adult Guardian (2004). *Annual Report 2003-04*. Brisbane: Queensland Government.

Office of the Public Advocate. (2004). *Annual Report 2003-04*. Brisbane: Queensland Government. P.41.

People with Disability Australia Incorporated, (2005); PWD e-bulletin, Issue 20.  
[www.pwd.org.au/e-bulletin](http://www.pwd.org.au/e-bulletin)

Petersilia, J., Foote, J., & Crowell, N. A. (2001) *Crime Victims with Developmental Disabilities: Report of a Workshop*. Washington DC: National Academy Press.

Office of the Federal Privacy Commissioner (2000). *National Privacy Principles: Privacy Amendment (Private Sector) Act 2000*. [www.privacy.gov.au](http://www.privacy.gov.au)

Queensland Police Service (2004). *Annual Report 2003-2004*. Brisbane: Queensland Government.

Queensland Police Service (2004). *Annual Statistical Review 2003-2004*. Brisbane: Queensland Government

Queensland Government, Department of Public Works. Source: [www.qgm.qld.gov.au/bpguides/conduct/coll.html](http://www.qgm.qld.gov.au/bpguides/conduct/coll.html)

Sherry, M. (2000). *Hate Crimes against People with Disabilities*. [www.wwda.org.au](http://www.wwda.org.au), accessed 19/05/2004.

Sobsey, R. (1994) *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance*. Baltimore: Brookes.

Strand, M-L., Benzein, E., Saveman, B-I. (2004). Violence in the Care of Adult Persons with Intellectual Disabilities. *Journal of Clinical Nursing*, 13, 506-514.

*Voices: People with an Intellectual Disability and Victims of Crime. Part A: Preventing Crime, Abuse and Exploitation within Services. Part B: Healing and Moving On.* (2000). Queensland: Alina Families Program, Community Living Association, & WWILD-SVP Service.

Westcott, R. (2004). Lives Unrealised: An Essay on Society's Response to Disability. Part 1: A Grisly History. *Interaction* v.18/1'04.

Westcott, R. (2004). Lives Unrealised: An Essay on Society's Response to Disability. Part 2: The Australian Experience. *Interaction* v.18/2'04.

White, C., Holland, E., Marsland, D., & Oakes, P. (2003) The Identification of Environments and Cultures that Promote the Abuse of People with Intellectual disabilities: a Review of the Literature. *Journal of Applied Research in Intellectual Disabilities*, 16, 1-9.