



# Victorian Parliamentary Inquiry into Social Inclusion for People with a Disability

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The Executive Officer  
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## **Introduction**

Since 1988, Women's Health West (WHW) has actively contributed to the health, safety and wellbeing of women in the western region of Melbourne through a combination of direct service delivery, research, health promotion, community development, capacity building, group work and advocacy. Since 1994 WHW has delivered family violence services for women and children ranging from crisis outreach and court support, to housing establishment and crisis accommodation options, to counselling and group work programs. WHW has been an active and strong supporter of family violence reform at a regional and statewide level, integrating and coordinating family violence services in our region, and ensuring the integration of those services with a range of related sectors, including the housing sector.

WHW also have a health promotion, research and development arm, which offers a range of programs and projects targeted to prevention and early intervention strategies to improve outcomes for women's health, safety and wellbeing. We are leaders in the development of regional strategies to further our work, seeing partnership within and outside the sectors in which we work as crucial for bringing about effective and sustainable outcomes for women and children.

These two main arms of the service place WHW in a unique position to offer a continuum of responses from prevention to early intervention to crisis response. WHW's strategic plan sets out our approach to partnership and our client-centred approach to service delivery and outcomes that support women to take control over their decisions and their lives.

### **Women's Health West's experience and expertise in working with women with a disability and female carers**

WHW has a long history of working with women with a disability and their female carers to enhance their health, safety and wellbeing. Our health promotion programs that aim to improve social inclusion for women with a disability and women who are carers of people who experience mental illness are:

- Sunrise – a program that offers friendship, social connectedness, information and skills development for women in the west who identify as having a disability
- Power On – a twelve-week strengths-based, peer education program that encourages women who experience mental illness to access information, develop skills, build support networks and enhance their health and wellbeing
- Power On for carers – an eight week peer education program for women who are carers of a person who experiences a mental illness that aims to enhance wellbeing

### **Response to the terms of reference**

WHW welcomes the opportunity to provide evidence and recommendations for reform to the Inquiry into Social Inclusion of Victorians with a Disability, and we commend the Victorian Government for initiating this inquiry. Victoria has made a clear commitment to the full and equal social participation of people with a disability in the *Victorian State Disability Plan 2013–2016* and the *Disability Act 2006*. This includes the critical need to redress harmful stereotypes, stigma and violence that undermine the health and wellbeing of people with a disability and contribute to their exclusion from social life. In this submission WHW argues that discrimination is

experienced differently by women and men with a disability. To highlight the impact of gendered practices on the social inclusion of women with a disability we have provided detailed analysis in the areas of violence against women and sexual and reproductive health. These are areas of priority and expertise for WHW, and as our submission shows, are critically linked to social inclusion for women with a disability.

*1. Define 'social inclusion' for Victorians with a disability.*

The United Nations Convention on the Rights of Persons with a Disability (2006), which Australia ratified in 2008, defines disability as any 'long-term physical, mental, intellectual or sensory impairment which, in interaction with various barriers, may hinder ... [a person's] ... full and effective participation in society on an equal basis with others'. The social model of disability recognises that for people with a disability it is not their disability or impairment that is disabling, but rather systemic barriers, prejudice and social exclusion that creates disadvantage and impedes their freedom, dignity and human rights (WHW, 2013).

Social inclusion – including supportive relationships, involvement in group activities and one's community and civic engagement – are important aspects to optimal health and wellbeing and a key social determinant of mental health (VicHealth, 2005). Social inclusion is commonly conceptualised as a multi-dimensional process that enables people's participation in economic, social, political and civic domains (Silver, 2010). Women's Health West (WHW) recommends that social inclusion for people with a disability therefore be defined as equitable participation across social, economic, political and cultural systems and structures that result in their meaningful integration into the wider community. A socially inclusive society for people with a disability is therefore one 'where all people feel valued, their differences are respected, and their basic needs are met so they can live with dignity' (Cappo, 2002).

*2. Identify the nature and scale of relative inclusion (exclusion) and participation of Victorians with a disability in the economic, social and civil dimensions of society.*

Social exclusion is a theoretically contested concept (Silver, 2010). However, it is commonly defined as a multi-dimensional process and a form of complex inequity that results in people being shut out of economic, social, political and civic domains (Silver, 2010). People with a disability and in particular women with a disability experience social exclusion and disadvantage at a societal and individual level, across various domains and throughout their life course (Smyth, 2010).

Research shows that people with disabilities are more likely to live in poverty, have poor-quality and insecure housing, low levels of workforce participation and education, experience higher rates of violence and discrimination and experience more difficulty accessing appropriate health care, when compared to people without a disability (VicHealth, 2012). Self-reported health status is worse for people living with a disability, with thirty-five per cent of people stating that their health is poor to fair compared to 5 per cent for people without a disability (VicHealth, 2012). People with a disability are also more likely to have a chronic illness and experience the

onset of many chronic conditions earlier than people without a disability (VicHealth, 2012).

When exploring the relative exclusion of women with a disability compared to their male counterparts, research shows that women experience more acute exclusion, otherwise known as 'deep exclusion' across more domains (Smyth, 2010). Women with a disability experience higher rates of poverty, housing insecurity and stress, lower levels of education and employment, when compared with men with a disability and women who do not have a disability (VicHealth, 2012). Almost half of Australian women with a disability are shut out of employment; with only 49 per cent participating in the workforce compared with 60 per cent of their male counterparts (ABS, 2012). High rates of gender-based violence also compound the social exclusion and poor mental health outcomes of women with a disability. Statistics indicate that 90 per cent of women with an intellectual disability have been sexually assaulted compared to approximately one in five of Australian women (Frohman, 2002; ABS, 2012). A Victorian study of women with a disability living in licensed boarding houses reported that violence is a daily lived experience (Attard and Price-Kelly, 2010).

Negative stereotypes associated with gender and disability further compound the exclusion of women with a disability, particularly in relation to their sexual and reproductive health rights (WWDA, 2011a). Relative to women without a disability, women with a disability are less likely to have access to sexuality education and health services, are more likely to experience pressure to terminate pregnancies as well as lack of timely access to their choice to termination of pregnancy, limited parenting support and a disproportionate representation in child protection cases (WWDA, 2011a). Indeed, many women with a disability are excluded through social systems that impede on their ability to become pregnant and parent. For example, involuntary and coerced sterilisation is a gendered practice that primarily affects women and girls and is related to their systemic discrimination and exclusion from equitable participation in the Victorian community (Frohman, 2002).

### *3. Understand the impact of Victorian government services and initiatives aimed at improving inclusion and participation*

#### **Access to inclusive sexuality education and sexual and reproductive health services**

All people have the right to develop positive sexual relationships, to maintain good sexual health, to be parents, and to access safe and affordable contraception and reproductive services if they choose to. According to the World Health Organisation (WHO) the social determinants of sexual and reproductive health work 'at different levels to influence exposure to the risks of unintended pregnancy or sexually transmitted infection, care-seeking behaviours, and access to and use of preventative services, care and treatment' (WHO, 2010: 10). It is therefore extremely significant that many people with a disability continue to experience systematic exclusion from sexual and reproductive health services, information and education (Frohman, 2013). This form of social exclusion has a disproportionate impact on

the health and wellbeing of women with a disability. Exclusion from sexual and reproductive health education is often justified as a means of preventing sexual abuse by limiting sexual expression, which is an assumption that is not informed by current evidence (Frohman, 2013; Shuttleworth, 2007). Research indicates that a 'lack of adequate sexual education and training for people with intellectual impairments puts this population at an even higher risk for sexual abuse' (Shuttleworth, 2007: 6). Victorian government services and initiatives play an important role in ensuring that people with a disability are able to express their sexuality in a safe and positive way, and can access services that recognise their complex and diverse needs. It is also essential that people with a disability are provided with the knowledge, skills and confidence to approach health professionals or significant others if they have been assaulted, abused or exploited.

The *Victorian Personal Relationships, Sexuality and Sexual Health Policy and Guidelines: Disability Services* (Victorian Department of Human Services, 2006) has been identified as an example of a best practice policy framework to support inclusive services (Sexual Health and Family Planning Australia, 2013). In particular, WHW commends the rights based approach that underpins this policy, and attention to relationships and other social aspects of sexuality.

To meet the objectives set out in this policy, agencies require specialist training and resources to support the sexual and reproductive health needs of clients with a disability. To increase transparency in this area, greater clarification is needed in regards to how this policy or other resources continue to influence practice in the Victorian Department of Human Services' (DHS) disability services and the disability sector more broadly. It is also essential that barriers to accessing sexual and reproductive health services, information and education identified by disability support workers are able to influence practice in relevant public health agencies.

**Recommendation: Build on the Personal Relationships, Sexuality and Sexual Health Policy and Guidelines: Disability Services and fund and resource services to implement these guidelines, including strengthening links to appropriate services**

**Recommendation: Fund workforce development programs to build the capacity of disability support workers and the health sector more broadly to meet the sexual and reproductive health needs of people with a disability**

#### *Access to inclusive sexuality education*

Participation in respectful relationships and sexuality education at school is important for young people to reflect on their sexuality and to gain the information they need to make safe and informed decisions about their sexual and reproductive health. In Victoria, sexuality education is a compulsory component of the new AusVELS curriculum from prep to year ten, and was previously covered in the Victorian Essential Learning Standards (VELS). WHW commends the Victorian Government on its work to embed comprehensive sexuality education in schools. However, we

urge government to review the curriculum standards and the supporting materials provided to schools, to improve inclusion and participation of students with a disability.

Adaptation of materials into formats that meet the learning needs of people with a disability is critical for ensuring that these students receive the same opportunities as their peers. This need is reflected in *Catching On Early*, which states,

*Students with disabilities need the same information as everyone else. Students with learning disabilities should still receive information that is relevant to their age, for example, information about puberty; however, the teaching methods may need to vary to accommodate the disability. Students with disabilities may need additional information relevant to their particular disability* (Victorian Department of Education and Early Childhood Development, 2011: 22)

While this is an important position statement, the resources and support available to facilitate alternative lesson plans that are responsive to the needs of students with a disability are still extremely limited. Family planning agencies around Australia, including Family Planning Victoria, have developed materials and training programs designed to supplement the sexuality education curriculum to support people with a disability. It would be beneficial to assess utilisation, accessibility and evaluation of these resources, particularly in rural and regional areas, and to identify gap in materials where schools might be experiencing difficulties in meeting to information needs of their students. Many of the existing resources focus on sexuality education for people with an intellectual disability. However, there are also significant sexual and reproductive health concerns that are specific to people with physical, communication and sensory impairments and to those who experience mental illness. Adaptation of the curriculum to meeting the learning needs of students with a disability is broadly covered by *The Disability Standards for Education 2005*. However, many school providers who provided feedback to the 2011 review of the standards highlighted the need for greater clarity on the responsibility of schools to make 'reasonable adjustments' (Australian Government, 2012). This indicates that a need to clarify where government will provide additional resources, particularly in relation to sensitive subjects such as sexuality education.

Discrimination and negative cultural and social attitudes are among the most significant barriers to the inclusion of people with a disability in education and training around sexual and reproductive health (WWDA, 2014). In addition to adapting learning environments and resources, sexuality education should promote inclusive standards by representing the sexuality of people with a disability in a positive way. To overcome the systemic discrimination and stigma that people with a disability experience in relation to their sexuality, we recommend the inclusion of 'ability and sexuality' as a key learning concept in the section of the curriculum that covers sexuality education. This could be supported with the inclusion of scenarios and activities in *Catching On Early* and *Catching On Later* that positively represent intimacy, sexual expression and parenting for people with a disability. Facilitating discussion around ability and sexuality is important for all students regardless of their

current ability, as it will inform their attitudes towards people with a disability who might be friends, family, clients or lovers, and prepare them for potential changes in their own ability.

**Recommendation: Fund research into best practice approaches to the inclusion of students with a disability in sexuality education programs, including a review of current practice and resources utilised in Victorian schools**

**Recommendation: Advocate for the inclusion of 'ability and sexuality' as a learning focus in the within the Health and Physical Education component of the AusVELS Curriculum**

**Recommendation: Fund the development of and support the availability of up-to-date sexuality education professional development for all Health and Physical Education teachers, with a focus on ability and sexuality**

**Recommendation: Update *Catching On Early* and *Catching On Later* to include case studies and activities that present positive representations of sexuality for people with a disability**

#### *Access to sexual and reproductive health services*

As a result of positive trends in government services and initiatives aimed at desegregation and improving social inclusion, an increasing number of women with a disability are engaging in sexual relationships, experiencing pregnancy and becoming parents. However, significant barriers remain in women's access to appropriate government funded sexual and reproductive health services. Available literature indicates that women with a disability continue to experience strong social disapproval when negotiating parenting options and other aspects of their sexual and reproductive health that results in pressure to comply with decisions imposed upon them (Burgen, 2010; WWDA, 2014; Anderson and Kitchin, 2000). The following case study and examples highlight the harm that can be caused by negative cultural attitudes towards the sexuality of people with a disability, including social isolation and participation in unsafe sexual practices.

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

**Source: WWDA (2014) *Submission to the national inquiry into equal recognition before the law and legal capacity for people with disability***

Reactions of disbelief around the capacity of women with a disability to be parents were raised in WHW's consultations for Beyond Symptoms, with one women stating, 'When I said I wanted to have children and he looked at me and said, 'how could you look after children properly?' (WHW, 2002: 96).

In 2005, the Royal Women's Hospital initiated an audit of women with cognitive impairments who had contacted the Pregnancy Advisory Service seeking support with an unplanned or unwanted pregnancy. Their findings indicate that women with an intellectual disability are accessing family planning services later in their gestation, with 45 per cent of women contacting the Pregnancy Advisory Service at 12 weeks gestation or later (Burgen, 2010). Delayed recognition of pregnancy, delayed contact with services, external pressures on decision-making and additional complex support needs of women with an intellectual disability, indicate the need for specialised support services. This is an area where addition investment from the Victorian Government will have a significant impact on the social inclusion of women with a disability.

While there are some excellent public sexual and reproductive health services in Victoria responding to the complex needs of women with a disability, more data is needed on the accessibility of mainstream sexual and reproductive health and family planning services across the state. Currently the Royal Women's Hospital provides specialist antenatal support for women with acquired brain injuries, intellectual or learning disabilities, physical disabilities or sensory impairments, through the Women with Individual Needs (WIN) Clinic. In addition the WIN Social Worker can provide urgent specialist counselling for women with cognitive impairment who have contacted the hospital's Pregnancy Advisory Service to assist them in decision making about an early unplanned pregnancy, as well as specialist assessment of the impact of their disability to ensure that treating health professionals are aware of the women's capacity to give informed consent or the need to access appropriate government advocacy bodies to protect their legal rights.

Family Planning Victoria provides sexuality education to clients with an intellectual disability, and pregnancy options information. However, despite these services there is significant unmet demand for immediately accessible comprehensive responses to women dealing with unplanned pregnancy. For instance in Victoria there is no dedicated state-wide unplanned pregnancy counselling and referral service, and this not only creates access issues for all women but in particular women dealing with disability attempting to locate accessible and relevant information and services.

In Melbourne's West, a mapping exercise completed by Women's Health West in 2010 only found one sexual and reproductive health initiative specifically designed for women with a disability; PapScreen Victoria's We are Women Too program (WHW, 2010).

With the implementation of the National Disability Insurance Scheme (NDIS) there is potential for individuals to advocate for sexual and reproductive health services. However, given the stigma attached to sexuality and reproductive choices for people with a disability, individuals might not feel safe to raise the topic with their case



planner. Thus, self-advocacy support is critical in this area and should be supported with positive representations of sexuality for people with a disability in planning tools, state level training and government communication strategies for the NDIS.

**Recommendation: Undertake research to map the accessibility of sexual and reproductive health across the state for people with a disability, and fund services and program to meet any identified gaps**

**Recommendation: Include prompts around sexual and reproductive health services in NDIS planning tools and provide training for case planners to overcome cultural biases concerning disability and sexuality**

**Recommendation: Provide clear information on the availability of advocacy support during NDIS planning processes, and role that advocates could play to assist individuals to have difficult conversations around sexual and reproductive health needs**

### **Freedom from violence**

Violence against women with a disability in the home and in institutional and residential care settings continues to occur at unacceptably high rates, undermining their ability to participate as full and equal citizens in our society (WWDA, 2011; Office of the Public Advocate, 2010; WDV, 2008). Effective response services and investment in initiatives that prevent violence before it occurs should therefore be a priority for a Victorian government committed to the social inclusion of people with a disability. Action in this area requires attention to intersectional experiences of gender and disability, and WHW commends the state government on recent commitments to specifically redress violence against women with a disability.

In 2008 Women with Disabilities Victoria was funded to assess the extent to which Victorian family violence policy and practice recognises and effectively responds to women with a disability. The *Building the Evidence Project* sets out best practice standards for service response. The adoption to these standards and appropriate support and funding from government is essential in responding to the high levels of social isolation among women with a disability who experience violence and abuse. The standards include:

- Adoption of an inclusive definition of family violence
- Inclusion of information about the diverse experiences of women and children with a disability
- Disaggregated data to improve the visibility of people with a disability and their service needs
- Identification of disability as a risk factor
- Accessible information, communication and premises
- Cross-sector collaboration
- Clear links between family violence sector standards, codes and guidelines and relevant disability legislation

- Gender perspective
- Human rights/social justice perspective
- Workforce development (WDV, 2008)

The need for services that are more inclusive and responsive to the complex needs of women with a disability has also been recognised by the family violence sector. In 2010, WHW secured funding through the Victorian Department of Human Services to provide intensive case management for women with disabilities who experience family violence. This project also involved interagency collaboration to improve access and referral pathways across the western region, and in 2013 the Western Region Family Violence and Disability Services Network adopted all recommendations proposed for regional service improvement (WHW, 2013).

To continue service improvement, government support, allocated funding and clear frameworks for cross-sector collaboration are critical. The Victorian Government Disability and Family Violence Crisis Response Initiative establishes an important framework for this work. The initiative provides immediate disability support to secure appropriate accommodation and up to \$9,000 to assist with the purchase of attendant care, equipment hire or transport (DHS, 2014). For women with a disability who experience family violence, limited options in accommodation and disability support are key factors influencing their decision to leave. Many women do not have access to independent finances or alternative disability supports and cannot afford to be in an extended period of transition. Additionally, access to 24 hour attendant support is extremely important for women leaving violence, who have complex needs in decision making, information processing and managing anxiety. However, women with a disability frequently experience barriers accessing 24 hour refuge accommodation, as assessment must prioritise women who are experiencing immediate life threatening danger.

While the Disability and Family Violence Crisis Response Initiative is definitely a commendable effort to support women with a disability experiencing violence, rigorous evaluation is critical to ensuring that the program response is meeting its objectives and having a positive impact on women. The case study below highlights how the complicated assessment processes and delays in access to secure accommodation can significantly impact the effectiveness of this initiative.

Beth<sup>1</sup> is a middle-aged woman with an intellectual disability and chronic health and mobility support needs. Beth's daughter is her main carer and informal guardian. Beth participates in a regular social support group for women with a disability. She disclosed to a friend in the group that she was fearful to be alone in her home with her daughter's partner, who frequently calls her derogatory names and has spat in her face. Staff from a local district nursing program also reported that due to the risk of violence, it was unsafe for nursing staff to enter the home to address and monitor Beth's health needs. The risk of Beth not obtaining such assistance is life threatening given her medical history. Beth was offered temporary accommodation with her friend and was later referred to a family violence service.

<sup>1</sup> Name changed and identifying details removed to protect confidentiality

With the support of her case worker, Beth relocated to a hotel, and made a claim for funding to the Disability and Family violence Crisis Response Initiative. Immediate financial support which was required in order to secure appropriate short-term supported accommodation, and ensure Beth had continued and unhindered access to healthcare and nursing services. The intention of the Disability and Family Violence Crisis Response Initiative is to provide 'immediate response' with no formal diagnosis of disability required. However, Beth experienced a lack of clarity around protocols for access to the funding and no immediate assistance through the Disability and Family Violence Crisis Response Initiative. After experiencing significant delays in confirmation of funding and supported accommodation, she became extremely anxious that she would be left with nowhere to go. At this point, Beth was contacted by her daughter who convinced her to return home.

**Recommendation: Increase funding available through the Disability and Family Violence Crisis Response Initiative for women with a disability who need 24 hour attendant support whilst future support services are yet to be determined**

**Recommendation: Provide specialised crisis support accommodation that is solely for women with an intellectual disability who require 24 hour attendant support in decision making and processing information, with an assessment process that is responsive to their unique needs**

**Recommendation: Work with disability and family violence sectors to evaluate the progress of Disability and Family Violence Crisis Response Initiative to ensure that the program is meeting its aims**

**Recommendation: Invest in prevention of violence against women initiatives that are responsive to the experiences of women with a disability, as a mechanism to promote and ensure their social inclusion**

*4. Identify examples of good practice on inclusion and participation driven by local government and the community sector*

Good practice in this area prioritises the voices and expertise of people with a disability, through continuous reflection and strengths based approaches to engagement. Accessibility is also an important consideration for programs that aim to overcome acute isolation experienced by many people with a disability, and women in particular. While physical access is an important part of this, it is equally important to consider whether application processes are appropriate, unthreatening and as simple as possible. For example, many specialised disability programs or support groups are extremely unlikely to be utilised by people without a disability. In these cases, self identification might be all that is required. Local government and the community sector play an important role in facilitating social support groups, developing innovative education models and informing systemic change to redress discrimination and improve social inclusion for people with a disability. The following examples highlight the benefits of locally based programs.

## **Sunrise Women's Groups**

Funded through Home and Community Care (HACC) Services, WHW's Sunrise Women's Groups provide safe, inclusive, and supportive social group activities for women with a disability to improve their health and wellbeing in an environment that is welcoming and is responsive to their individual needs. There are currently three Sunrise groups, located in western metropolitan LGAs, with priority given to areas within the outer west growth corridors, and those areas where communities experience higher levels of disadvantage.

In 1988 WHW ran an assertiveness course for women with a disability, and the recommendation to establish a women's support group came from participants. From the beginning, women with a disability were actively involved in decision making processes for the group. The Sunrise Women's Group provides women with skills, information, resources and activities that are identified by the group through regular consultations. Its aim is to enhance women's ability to take control of their own health choices and decisions within their daily lives.

As the personal account below highlights, an important aspect of group is that it is local, easily accessible, and has an inclusive and responsive process for planning group activities. Sustainable funding secured through HACC as a planned activity group has been critical to the successful delivery of Sunrise. As such, the role of HACC funding should be recognised and considered when developing strategies to facilitate social inclusion of people with a disability. Following the complete implementation of the NDIS the Victorian state government will phase out funding for services intended to be covered under the new scheme. This will include many of the HACC services for people under 65 with a disability. As part of Victoria's agreement with the Commonwealth Government, the funding and management responsibility for all HACC services for people over 65 years will be transferred to the Commonwealth Government from 1 July 2015 (Commonwealth Government of Australia, 2013). Further clarification is needed on how this will impact on funding for planned activity groups to ensure that ease of access for all people who currently benefit from this form of social support, recognising that:

- Not all people with a disability will have access to the NDIS
- Access to social support groups often improves access to other services by reducing social isolation and anxiety
- Informally structured social support groups are not well suited to 'user pays' funding models
- If these groups were to become unavailable it would put current members at risk, and would further reduce social support options for women with a disability who experience high rates of isolation and exclusion

## **Sunrise Brought Me New Hope**

For many years I have suffered intermittent periods of debilitating depression and social anxiety.

The doctors, psychologists, books, therapies and pills could only help so much. I had lost touch with most of my friends and felt unable to cope with interacting with people most of the time. I felt desperately lonely and trapped in my house by anxiety and increasing agoraphobia. My physical health deteriorated. I had become morbidly obese, with all the health issues that come with that (mobility issues, high blood pressure, diabetes, low self-esteem and so on).

One day, I anxiously realised that I couldn't bring myself to walk out the front door to my letterbox. Thank god for my mother because during this period she would take me to appointments as I could not bring myself to leave the house on my own. I don't think even she realised how much it meant to me especially as she did not really understand my depression or anxiety issues and was more inclined to tell me impatiently to just shake myself out of it.

A chance meeting with an old friend planted the suggestion that I join a couple of women's groups she was involved with, to help me reconnect with people. I discussed it with my psychologist but it took me a further six months and several aborted attempts for me to work up the courage to go to my first session. This was two years ago.

The Sunrise Women's Group is coordinated by Women's Health West and meets every fortnight at a community centre, which is within easy reach of my home. When I first joined the group, the facilitator at that time, guided me through simple, unthreatening introductions. I was relieved that the only criterion for joining was that I felt I had a disability. (Unlike Centrelink who, at the time, were causing me even more desperate anxiety with their complicated assessment processes to get benefits).

On my first day, the Sunrise Group went ahead with their scheduled activities including me but not singling me out. At their own pace, the women individually, made time to say a few welcoming words and to tell me a bit about themselves. I learnt they had a strong commitment to the guidelines they had written for themselves which included not being judgemental, being kind and respectful of each other and treating any confidences shared in the group as confidential. We shared contact details and some of the ladies encouraged me to call them to chat. More than one of the ladies were willing to pick me up and drop me home as I don't drive and this helped even further with my anxieties.

Now, two years later, I look forward each fortnight, to meeting with the familiar faces of the ladies of the Sunrise Group. Over morning tea, we share stories, information, achievements, humour, joys and sorrows. Like any group we have our dramas and our ups and downs but we weather them. Our new group facilitator keeps us on track and arranges inspirational speakers, learning experiences, excursions and shared activities. I always leave feeling happier than when I arrive.

I still continue to suffer periods of illness when I withdraw from the world for a time. But now I have people who care, who I can call when I am ready to talk to someone, who encourage me to come out of my isolation with slow easy steps, who raise my self-esteem and accept me just as I am. This has made my disability a hundred times easier to bear. Thank you to the wonderful women of the Sunrise Women's Group.

**Source: WHW (2014) *Personal account written by a member of a Sunrise Women's Group***

### **Living Safer Sexual Lives: Action research and peer education program**

Living Safer Sexual Lives was a three year VicHealth funded action research project undertaken by Latrobe University's Australian Research Centre in Sex, Health and Society (ARCSHS) between 1999 and 2001. The project aimed to establish a better understanding of how people with an intellectual disability saw their sexual lives and relationships, and through consultation develop a sexuality education model that would help them to lead safer sexual lives (Frawley et al, 2001). In 2009, the ARCSHS received further federal funding to deliver the Safer Sexual Lives education

program, with a focus on respectful relationships, in five sites across Victoria and Tasmania.

The program uses a peer education model that puts women with an intellectual disability at the centre, as key agents of social change. Women with an intellectual disability actively participated in the development and implementation of the program, working alongside researchers as research assistants, project workers, and peer educators (Frawley et al, 2012). WHW endorses the program as, in line with best practice primary prevention of violence against women, it seeks to redress violence and abuse on individual, community and societal levels. It offers a strong contribution to the development of an evidence base with regard to the prevention of violence against women with a disability. This departure from outdated protective education programs and the attention to positive representations of sexuality is critical to improving social inclusion of women with a disability, and promoting their right to maintain healthy and respectful relationships.

### **Systemic advocacy and representation of women with a disability**

WHW acknowledges the importance of ongoing work to facilitate civic participation and increase the visibility of women with a disability, including opportunities to influence policy and law reform processes, and to redress discrimination. Given the complex interplay of gender and ability in the forms of discrimination and social exclusion experienced by women with a disability, it is important that expertise in this area held by community sector organisations is recognised. In Victoria, **Women with Disabilities Victoria (WDV)** has a strong record in providing support to government in relation to service improvement, and policy and law reform development, particularly in relation to preventing violence against women, which is a major contributor to the isolation and exclusion experienced by women with a disability. WDV is currently developing an exciting new training program aimed at improving the quality of gender sensitive practice amongst disability service managers and workers as a strategy for violence prevention.

**Recommendation: Provide clarification on how social support groups for people with a disability will be funded following the roll out of the NDIS in Victoria**

**Recommendation: Continue to fund and consult with the women's health sector to ensure appropriate representation of the unique experiences of women with a disability, recognising the expertise of Women with Disabilities Victoria**

**Recommend: Fund the continuation of the Living Safer Sexual Lives: Respectful Relationships program developed by La Trobe University, and explore options for further sexuality education for people with a disability based on this peer-education model**

#### *5. Assess how the Disability Act 2006 has impacted on the social inclusion of people with a disability with respect to Victorian government services*

The *Disability Act 2006* recognises that people with a disability continue to experience high levels of exclusion and isolation, and establishes an important rights based framework for social inclusion. One of the key strengths of the Act is that it introduces specific safeguards around the use of restrictive interventions by creating

new reporting requirements for disability service providers. Restrictive interventions are defined as 'any intervention that is used to restrict the rights or freedom of movement of a person with a disability, including mechanical restraint, chemical restraint, and seclusion' (Disability Act 2006: 9). Part 7 of the Act states that the use of restraints or seclusion must be included in the person's behaviour management plan (Disability Act 2006: 139). An 'independent person' must be available to explain the details of the plan to the person with a disability, and all plans must be submitted to the Senior Practitioner<sup>2</sup> within two days of approval, with the name and details of the independent person who assisted. This protocol and the investigative powers of the newly established Senior Practitioner increases accountability around the use of restrictive interventions, and the likelihood that significant abuses of power will be brought before the Victorian Civil and Administrative Tribunal (VCAT) for review.

Restrictive practices have been observed in a wide range of settings, including schools, group homes, residential care facilities, private homes, hospitals, prisons and mental health facilities. While there are circumstances where restraint is necessary to prevent harm to the person with a disability or others, there is evidence to show that such practices are frequently used as a mechanism of control and not in the best interest of the client (WWDA, 2011b). The Australian Psychological Society has called on the Australian Government to take urgent action to end restrictive interventions, stating:

*'Vulnerable children and adults with disabilities, some of whom have difficulty even communicating what has happened to them, continue to be exposed to the risks inherent in using restrictive practices, which in some cases led to death and which are certainly in violation of their human right'* (cited in WWDA, 2011b: 18)

Many women with a disability who have experienced violence and sexual abuse have complex support needs. As restrictive interventions have been shown to exacerbate psychological distress, it is important to behaviours associated with past trauma are recognised and treated with appropriate counselling and support (Spivakovsky, 2012). Studies show that staff training and support is essential to ensuring higher quality behaviour support plans, with fewer restrictive interventions (Spivakovsky, 2012). Thus, sustained government support for professional development for disability service providers is needed to overcome acute isolation experienced by many people with a disability.

While there are multiple sections of the *Disability Act 2006* that promote the social inclusion of people with a disability, we choose to focus on restrictive intervention because this practice can create or exacerbate poor mental health and have a negative impact on self esteem, self advocacy and therefore, on social inclusion. Women with poor mental health and poor self esteem are more likely to become socially isolated and will experience greater barriers to accessing support. Access to timely and appropriate education, counselling, and other forms of positive support are critical for ensuring social inclusion for people with a disability is valued, and interventions that restrict their decision making or freedom of movement are monitored and minimised. Action in this area should apply for all people with a disability, including those who experience mental illness, in all settings where restrictive interventions have been observed.

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<sup>2</sup> The Senior Practitioner is a new role established by the Disability Act 2006, and is responsible for monitoring the use of restrictive interventions and providing guidelines and information to improve practice

**Recommendation: Fund training for disability workers and carers on responding to challenging behaviours without the use of restraints, with a specific focus supporting women who have experienced violence and sexual abuse**

**Recommendation: Continue work with the Victorian Equal Opportunities and Human Right Commission to reduce restrictive practices in Victorian schools**

**WHW also supports the recommendation from the Office of the Public Advocate that:**

**'The Victorian Law Reform Commission undertake an inquiry into legislative controls and reporting requirement across the disability, mental health and aged care sectors' (Spivakovsky, 2012: 10)**

6. *Recommend ways to increase social inclusion, including the roles of and collaboration between local, state and federal governments, the community sector, individuals with a disability and their carers*

See recommendations outlined above

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