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Disability and domestic violence: protecting survivors' human rights

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Survivors with disabilities experience domestic violence both more often and differently to those who do not have a disability. The presence of impairment substantially transforms the medical, psychological, environmental, economic, legal and political factors which contribute to the occurrence of violence. Survivors of domestic violence are often highly dependent on their abuser, fear disclosing abuse and lack economic independence, and these issues may be heightened for a person who also has a disability. Domestic violence is amplified by the existence of impairment when law enforcement and medical bodies construct the survivor and their relationship with the perpetrator through an oppressive disability model. Advances in theory and international disability human rights laws may provide new and powerful avenues to critique how law and practice in Australia responds to disability domestic violence. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the first human rights convention to specifically protect survivors with disabilities from domestic violence. In this article, we use critical disability studies and the CRPD to identify limitations with Australia's responses to disability domestic violence.

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Introduction

Physical violence against women and children, perpetrated by a husband or father, was not held to be unlawful in Australia until the nineteenth century,[1] and it was not until 1992 that all jurisdictions in Australia regarded non-consensual sexual intercourse within a marriage as rape.[2] Australian jurisdictions have only recently begun to recognise non-physical forms of abuse, such as emotional and financial abuse, and stalking, as domestic violence.[3] The process of effectively criminalising the most egregious forms of domestic violence remains an unfinished story.[4]

One aspect of domestic violence that is only now starting to be exposed more widely is how people with disabilities experience domestic violence both more often and differently to those who do not have a disability.[5] We refer to this different context and experience as 'disability domestic violence'. While we recognise that many persons with disabilities experience violence in group homes, boarding homes and other care facilities, violence in such facilities is regulated by separate legislative

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[1]Seddon (1993), Ch 1; Lemon (2001), Ch 1.
[2]Larcombe and Heath (2012), p 786.
[3]Australian Law Reform Commission (2010), see especially Ch 5.
[4]See, for example, Douglas (2008).
[5]Brownridge (2009); Healey et al (2013), p 52.

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regimes and is beyond the scope of this article.[6] Our focus in this article is on disability domestic violence perpetrated by an intimate partner. As illustrated in Part II of this article, disability is defined differently across laws and theoretical models. Some disability scholars argue that society understands disability by constructing a 'species-typical' level of ability, and then casting a person as having a disability as anyone who cannot meet this standard.[7] In this article we will draw from legislative definitions as a convenient line to where society distinguishes between able and disabled. We will then critically analyse how impairment influences the medical, psychological, environmental, economic, legal and political factors that contribute to unique forms of domestic violence experienced by people with a disability.

Persons with disabilities continue to experience direct and indirect discrimination[8] and heightened vulnerability to violence in the community.[9] In a domestic setting, disability may amplify individual vulnerabilities to violence. Disability is often associated with reduced economic status, the reduced capacity of survivors to make complaints and the greater risk that those complaints will be inappropriately actioned.[10] While those who experience domestic violence may be highly dependent on their abuser, fear disclosing abuse and lack economic independence, these issues could be heightened for a person with a disability.[11] Limits in communication may interact with other barriers to inclusion in society to increase the isolation of the person and their risk of domestic violence.[12] Domestic violence perpetrated on a person with a disability may also be more invisible and may be perpetrated in unique ways that diverge from forms of domestic violence explicitly recognised in policy and legislative instruments.[13] In part, as a result of these interrelated factors, rates of disability domestic violence are much higher, proportionately, than other forms of domestic violence.[14] Despite this, the complex relationship between disability and domestic violence has received insufficient examination to date.[15]

While many scholars have recognised that Australian law and legal institutions respond inadequately to domestic violence,[16] we argue that the legal response to domestic violence where the survivor has a disability is particularly problematic.

[6]We thank the anonymous reviewer for pointing out that this separation in itself may be problematic and it underlines the impact of the medical model of disability on the legal responses to domestic violence; see also Attorney General's Department (SA) (2007), p 52; Pyke (2007).

[7]Campbell (2009), p 19.

[8]Obvious examples include getting to court, giving evidence, completing forms and leaving the family home; see Australian Law Reform Commission (2010), pp 312, 845.

[9]McDermott (2012), pp 211–212.

[10]Australian Law Reform Commission (2010), p 306.

[11]WWDA (2007).

[12]WWDA (2007).

[13]This is discussed further in Part I of this article.

[14]Thiara et al (2001); PWDA (2013).

[15]See Healey et al (2013), p 63. In this article our focus in on those survivors who already have a disability and are abused, another issue of concern is that domestic violence can create disability, see for example the discussion of long term injury and disability perpetrated by the abuser in *R v Major* [2011] QCA 210.

[16]See, for example, Graycar and Morgan (2000), pp 303–308; Stark (2004); Hunter (2006).

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Scholarship has identified that laws respond poorly to the intersectional causes of domestic violence.[17] The failure of the legal system to protect survivors of domestic violence is amplified where impairment interacts with the physical, emotional, economic, legal and institutional dynamics associated with violence. We contend that many who are associated with criminal justice, domestic violence and sexual assault services do not understand or apply existing laws within the human rights framework articulated by the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[18]

Part I of this article considers how disability domestic violence may be manifested. It reviews published primary research that illustrates how the existence of an impairment leads to unique forms of domestic violence. The particular vulnerability of persons with disabilities is explained through theory and recognised under the CRPD. Part II will analyse how the CRPD, as the leading United Nations human rights convention protecting persons with disabilities, seeks to protect survivors with disabilities and Australia's obligations under international law to protect this vulnerable group.

Part III analyses how the different Australian jurisdictions seek to protect survivors with disabilities from domestic violence. There are three broad approaches to this protection. Some definitions of domestic violence specifically identify forms of violence to which survivors with disabilities are especially vulnerable.[19] Other jurisdictions identify emotional abuse or intimidation[20] as forms of domestic violence. In some jurisdictions domestic violence is defined very broadly as behaviour that is 'coercive or controlling'.[21] While most manifestations of disability domestic violence could come under these definitions, the existence of disability operates as a complicating and confounding factor.

Part IV will analyse how survivors with disabilities are especially disadvantaged when seeking to utilise legal protections. We argue that the state does not adequately ensure that survivors with disabilities have sufficient support to make complaints. When survivors with disabilities do reach out for help, there are often reports that survivors have their voice discounted by law enforcement agencies, health professionals and support services who embrace a medicalised construction of disability. For example, when police attend a domestic violence call out they may focus their attention on the carer's (i.e. perpetrator's) narrative of events, discounting the narrative of the person with a disability.[22] We argue that legislation in most jurisdictions has the capacity to improve the lives of survivors with disabilities if it is applied in a way that reflects the standards posited in the CRPD.

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[17] See, for example, Sokoloff and Dupont (2005).

[18] Preamble (q). The CRPD was adopted by General Assembly resolution A/RES/61/611 in 2006; entered into force generally 3 May 2008; ratified by Australia 17 July 2008; and entered into force for Australia 16 August 2008.

[19] See, for example, *Intervention Orders (Prevention of Abuse) Act 2009* (SA), s 8(4).

[20] See, for example, *Domestic and Family Violence Protection Act 2012* (Qld), s 11; *Family Violence Protection Act 2008* (Vic), s 7, *Restraining Orders Act 1997* (WA) s 6; *Crimes (Domestic and Personal Violence) Act 2007* (NSW), s 13.

[21] See, for example, *Domestic and Family Violence Protection Act 2012* (Qld), s 11; *Family Violence Protection Act 2008* (Vic), s 7.

[22] Thiara et al (2012), p 160.

Part I: How disability domestic violence manifests

This part considers how the presence of a disability often allows for unique forms of domestic violence to be perpetrated. Women with disabilities experience discrimination and negative stereotyping as a result of both their gender and disability identities.[23] When compared to women without disabilities, women with disabilities are 37.3 per cent more likely to experience domestic violence, with 19.7 per cent reporting a history of unwanted sex compared to 8.2 per cent of women without disabilities.[24] How violence is experienced can differ substantially depending on the nature of the disability experienced by the survivor.[25]

The role that gender, race, economic and social factors play in facilitating domestic violence is now better understood.[26] The existence of an impairment is another important point of intersection that adds further complexity to the way domestic violence is experienced.[27] As discussed below, some disability theorists have argued that constructions of 'normal abilities' in society results in the creation of disabling practices which turn impairments into disabilities. The disabling impact of laws and institutions can be evinced by the way in which structures in society respond to persons with disabilities that are experiencing domestic violence. This part will first consider the disabling impact of structures in society before considering how impairment itself also contributes to the creation of specific vulnerabilities to violence.

Researchers have shown that the legal system has often failed to provide survivors with adequate support. For example, issues have been identified with respect to the police response, completion of applications for protection orders, and access to legal advice and advocacy services.[28] The impact of these issues may be amplified when a person has an impairment. Some survivors of domestic violence have reported that the criminal justice system generally requires a survivor to respond to violence in a particular way before recognising the violence as a problem worthy of intervention. For example, current protection order legislation in Queensland refers only to emotions of fear,[29] yet some women report they experience anger as a response to domestic violence or even normalise it and feel 'numb'.[30] Similar to other survivors, survivors with a disability may not respond in an 'expected' way and this may be another obstacle to securing help. Survivors often require assistance to access justice responses. Isolating survivors from potential

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[23]Sobsey (1994); Lin et al (2010), pp 1264–1268. It is also recognised that women are likely to have other overlapping identities, for example, because of their race or ethnicity, or their identity as mothers etc: Garland-Thomson (2006), p 257.

[24]PWDA (2013).

[25]It is notable that research reports that persons with mental illnesses (such as schizophrenia and schizoaffective disorders, bipolar disorder, major depression or alcohol-induced disorders) experience the highest levels of sexual and physical domestic violence, see Hughes et al (2012), pp 1621–1629. See also Salthouse and Frohmader (2004).

[26]Sokoloff and Dupont (2005).

[27]Healey et al (2013), p 52.

[28]See Hunter (2006), p 40; Douglas and Stark (2010).

[29]*Domestic and Family Violence Protection Act 2012* (Qld), s 11.

[30]Stark (2007), p 96; Douglas (2012).

support networks is a tactic experienced by survivors with and without disabilities.[31] Survivors with disabilities are often particularly vulnerable to being isolated by their abuser due to mobility and communication limitations. Some survivors rely on their partners to facilitate their contact with family, friends and agencies.[32] Survivors with cognitive disabilities, for example, may have reduced capacity to communicate with authorities or respond in a way that is not 'recognised', and survivors with mobility problems may lack the ability to leave their home without assistance. When a survivor's primary means of communication with other people and services is via their partner, and that partner is abusive, the survivor will confront significant difficulties when attempting to escape, or seek assistance to respond to, an abusive situation.[33]

Survivors of domestic violence often come to the attention of medical professionals. Medical professionals are often one of the first persons survivors engage with about their experiences. While survivors may be reluctant to disclose domestic violence to their doctor,[34] this reluctance may be intensified in cases where the survivor has a disability.[35] While many people in the community hold the healthcare sector in high regard, people with a disability may be particularly fearful about the ramifications of disclosure, particularly where their abuser is also their primary carer.[36]

Historically, many people with disabilities have had negative experiences with the health sector. At its most extreme, experiences have involved physical, sexual and psychological abuse.[37] During the twentieth century people with disabilities often endured forced sterilisations, non-consensual medical experimentation and even death by targeted eugenic inspired euthanasia.[38] Whistle blowers' reports of ill treatment and persecution by health sector representatives continue to emerge.[39] There is evidence that abuse, such as forced sterilisations, continue to threaten persons with disabilities' experiences with the medical industry.[40]

Persons with disabilities confront the additional fear that their complaints about domestic violence will be constructed as a symptom of a psychological condition, rather than a complaint about a real event requiring police intervention. Mental illness is a feared label as such a diagnosis is associated with punishment, blame, stigma and 'state sponsored coercion in the forms of involuntary commitment and

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[31]Australian Law Reform Commission (2010), p 88.

[32]Radford et al (2006), pp 233–246; Nixon (2009), pp 77–89.

[33]Thiara et al (2001).

[34]Tan et al (2012).

[35]Dowse et al (2013). Threats of institutionalisation are especially concerning to persons with disabilities given the history of abuse in such settings: Broderick (2012).

[36]Morris (1991), p 10.

[37]Blatt (1970), p 16; D'Antonio (2004), p 45.

[38]Bryan (2010); Turda (2010), pp 84–85; Lemke (2013), pp 71–72. Some in the disability studies movement continue to draw connections between eugenics and genetic developments, aborting disabled foetuses and other medical practices: Wilson (2006), p 67.

[39]In *Russell v Royals* [2013] SAIRC 34 a patient with a disability was badly burned and attempts were made to cover up the neglect. For a general discussion of problems in reporting work health and safety breaches in the health sector, see Harpur (2014); Mack (2014).

[40]There is considerable evidence indicating that persons with disabilities continue to confront the risk from involuntary sterilisations, see O'Neill and Peisah (2011), Ch 15.

forced medication laws'.[41] Being aware of these fears, perpetrators often refer to a survivor as 'crazy' or in need of mental health treatment.[42] For most survivors a perpetrator has very little capacity to forcibly institutionalise them. However, for persons with certain disabilities the capacity of a perpetrator to have the survivor institutionalised is significantly increased;[43] this heightens the impact of such threats, especially where the perpetrator is the guardian or carer for the survivor. Whether or not fears associated with institutionalisation are justified, it is foreseeable that survivors who hold such fears would be reluctant to report abuse if this might result in a psychiatric diagnosis. This has led some survivors with disabilities to indicate that they would prefer to remain with the perpetrator than expose themselves to the violence they believe they would experience at the hands of health professionals.[44]

Feminist activists and scholars have recognised the diversity of women's lives and that their experiences are influenced by their intersecting identities.[45] While emotional, physical and sexual abuse are common forms of domestic violence for people regarded as both able and disabled, perpetrators often use survivors' disabilities to aggravate the impact of their violence.[46] This part will now analyse how impairment can create additional sites for domestic violence.

There are a number of forms of violence that are unique to people with disabilities. How this violence manifests depends upon the impairments experienced by a survivor. Survivors who require support from their partners for daily tasks can be especially vulnerable to abuse. For example, survivors who rely upon their partners can experience abuse when their partner threatens to care for them in a manner designed to control the survivor or to make her fearful for her wellbeing.[47] An example of a more active form of abuse occurs where a perpetrator leaves a survivor who requires assistance off the toilet on the toilet for hours.[48]

Survivors who rely upon mobility aids, medication or medical technologies are extremely vulnerable to partners who restrict access to such items. Perpetrators have been reported to hide, refuse to obtain, or administer medication to cause both emotional and physical harm.[49] As a form of entrapment and humiliation, perpetrators have left people in wheelchairs, left them stranded by hiding survivors' wheelchairs, and have prevented them from accessing external supports which would increase the survivor's independence.[50]

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[41]Lewis (2006), pp 339–341.

[42]Humphreys and Thiara (2003).

[43]The perpetrator has the capacity under the *Mental Health Act 2000* (Qld) to make an application that the survivor be subjected to an involuntary mental health assessment, where they reasonably believe that the survivor has a 'mental illness of a nature, or to an extent, that involuntary assessment is necessary' (s 17).

[44]Thiara et al (2012), pp 48–49.

[45]Crenshaw (1991); Grabham et al (2009).

[46]Thiara et al (2001).

[47]Hague et al (2011).

[48]Thiara et al (2012), p 37.

[49]Dillon (2010).

[50]Thiara et al (2001).

Threatening pets is not uncommon in domestic violence situations.[51] While survivors with or without disabilities have emotional attachments to pets, survivors with disabilities have significantly different relationships with their pets when those pets are service animals. While there is a need for further research on the impact of violence against service animals generally, it can be observed that such violence is foreseeable in a domestic violence situation. Service animals can assist persons with disabilities to manage their impairments. The most common examples of this relationship are guide dogs for the blind which assist people with blindness to mobilise safely and guide dogs for the deaf which help people with hearing loss to identify important sounds.[52] Assistance dogs are now being trained to assist people with a wide range of medical situations, including alerting people who experience type 1 diabetes when they are at risk of serious ketoacidosis,[53] managing the symptoms of post-traumatic stress disorder[54] and in a wide range of animal-assisted therapies.[55] Every jurisdiction in Australia recognises the importance of guide and assistance dogs by protecting their right to accompany their handlers in public places and certain residential environments.[56] If a perpetrator injures a service dog and prevents them working, this would have an extremely disabling impact upon a survivor with a disability. Similarly, threats to injure or immobilise a service animal can be particularly distressing for a person who relies on the animal for their independence.

Research leaves no doubt that disability may amplify the impact of domestic violence and contribute to unique forms of domestic violence. The next part of this article will build on theory to analyse how the CRPD has altered state obligations to respond to disability domestic violence. Parts III and IV will then consider whether Australian legal responses meet the new human rights standard posited in the CRPD.

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Part II: How international human rights laws have responded to disability domestic violence

The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[57] and the CRPD are the two most obvious sources of international law when considering domestic violence against persons with

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[51]Ascione et al (2007). This issue has become so prevalent that a key service in Queensland has established the *Pets in Crisis* foster care program and assists up to 20 pets to safety each month, see DVConnect http://www.dvconnect.org/?page_id=11.

[52]Harpur (2010).

[53]See Wells et al (2008). This study surveyed 212 people with type 1 diabetes and dogs as pets. The dogs in this research were pets rather than trained assistance dogs. The survey found that 138 (65.1 per cent) of respondents reported that that their dog had shown a behavioural reaction to at least one of their hypoglycaemic episodes. Based upon this result, and other similar results, this research found that dogs generally were able to detect hypoglycaemic incidents; see also Wells (2009).

[54]Lefkowitz et al (2005); Yount et al (2012).

[55]Tedeschi et al (2010).

[56]Harpur (2010); for example, see the *Disability Discrimination Act 1992* (Cth), ss 8 and 9.

[57]Adopted by the UN General Assembly in New York on 18 December 1979 ([1983] ATS 9).

disabilities. CEDAW is relevant to this discussion as most survivors of domestic violence are women.[58]

While CEDAW promotes equality for women in a number of areas, this convention does not contain a provision dealing with violence against women.[59] This omission in CEDAW has been remedied, to some extent, by the General Assembly's 1993 Declaration on the Elimination of Violence Against Women (DEVAW)[60] and CEDAW's General Recommendation 19: Violence Against Women.[61] General Recommendation 19 redefines what is required to achieve gender equality and provides that domestic violence impedes gender equality, and that the 'full implementation of the Convention require[s] States to take positive measures to eliminate all forms of violence against women'. While there is increasing acceptance under international law that domestic violence violates human rights,[62] these developments have not considered how the existence of impairment impacts on domestic violence.

The CRPD is the first human rights convention specifically to protect persons with disabilities' human rights, and more specifically for this article, it is the first convention that specifically deals with violence against persons with disabilities. As explained in the Preamble, the drafters of the CRPD:

> (q) Recogniz[ed] that women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,
> (s) Emphasiz[ed] the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities,
> (x) [Were] convinced that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities …

In order to promote equality and reduce violence against persons with disabilities, the CRPD places a range of positive and negative duties on state signatories to protect persons with disabilities' human rights. This part will analyse how the CRPD requires state signatories to protect survivors with disabilities against domestic violence. Australia's responses to this form of violence will then be considered in Parts III and IV of this article.

Theorising disability

The concept of equality in the CRPD was developed after a long political and theoretical journey. Before analysing the text of the CRPD, this article will explain

[58]Douglas (2012); see also Attard and Price-Kelly (2010), p 30.

[59]Merry (2003), p 952; Meyersfeld (2010), p 6. See also Lacey (2004), pp 13–56, for a critical examination of the approach of CEDAW.

[60]UNGA Res 48/104 (20 December 1993) UN Doc A/RES/48/104.

[61]UN Doc A/47/38.

[62]Harne and Radford (2008), pp 21–22.

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the theoretical developments which made the CRPD possible. The concept of disablement can be analysed through competing theoretical models. The social and critical disability studies are the three primary theoretical models used to analyse disability.[63] One of the most enduring approaches to disabilities is the medical model. As the name suggests, the model focuses on the medical aspects of disability.[64] Under this approach, medical professionals create criteria to guide their treatment. Part of this process involves labelling people as either able bodied or disabled.[65] In this binary labelling approach able bodied is a positive or aspirational category while disabled is a negative category which operates to devalue the person. While this categorisation process may be needed for identifying where treatment might be provided, it results in negative outcomes if it is applied to broader public policies.

The key element of the medical model is that it constructs impairment as a problem which is internal to the individual. The construction of impairments as a problem requiring cure or treatment is associated with eugenics[66] and with medical interventions that often cause minimal medical improvements but substantial harm to the lives of people with disabilities.[67] The limitations of the medical model are highlighted in situations where there is limited or no current means of 'curing' the impairment. Under this model it is posited that until medicine can 'cure' them, persons with disabilities are regarded as imperfect specimens who are unable to reach 'their human potential given their insufferable condition[s]'.[68] Under the medical model, persons with disabilities are not discussed in terms of equality or rights, but rather they are often regarded as people who must be cured or institutionalised. This model often results in the denial of autonomy, robbing people of their privacy, sexuality and humanity.[69] Under the medical model, the cause of this oppression is the 'problem' of impairment with the impairment being held to define people as 'abnormal, deserving of pity and care'.[70] Oliver argues that once impairments are constructed as the cause of disablement, then this arguably reduces the social consciousness about the role society plays in disabling people who fall outside the 'normal' range of abilities.[71]

During the 1980s, a new disability model emerged that shifted the focus away from impairment and onto the role of society in turning impairment into disability.[72] Social model scholars rejected the notion that disability was caused by problems with

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[63]Dowse et al (2009).

[64]Rees et al (2014), [para 6.3.2.1]

[65]Heymann et al (2014).

[66]Bryan (2010), pp 71–72; Turda (2010), pp 84–85.

[67]Some medical interventions are defined as 'soul-destroying': Oliver (1993, pp 16–17) cited in Campbell (2009), Ch 9.

[68]Roosen (2009), pp 1–3.

[69]Siebers (2008), pp 162–166.

[70]Rees et al (2014), [para 6.3.2.1].

[71]Oliver (1996), p 37.

[72]Bagenstos (2009), pp 7–13 describes 'the endorsement of a social rather than a medical model of disability' as 'the one position that approaches consensus within the movement'.

ability and focused on the external sources of disablement.[73] Instead of focusing on ability issues, social model scholars deconstructed disability discrimination to identify the causes of disablement.[74] So called 'strong social model' scholars use Marxist critiques to identify how capitalist structures result in people with impairments being excluded from the means of production and thus are turned into second-class ability citizens.[75] So-called 'weak social model' scholarship also turns the focus away from impairment; however, these scholars employ a non-Marxist critique.[76] To reject the problematising of functional limitations, non-radical social model scholars instead focus on disabling barriers, whether attitudinal, physical or political.[77] One limitation with the social model is its emancipatory focus on the structures of disablement. The rejection of the impact of medical narratives of disability have, in the lives of people with disabilities, been a key reason that new models, such as critical disability studies, were developed.[78]

Critical disability studies have developed 'across, through and with disciplines of the social sciences and humanities'.[79] Similar to social model scholars, the critical disability studies school rejects the notion that the social construct of disability is a problem requiring correction.[80] The key difference between the social model and critical disability studies schools is in what factors are considered in determining the causes of disablement.

One interpretation of the critical disability studies school focuses on cultural and linguistic critiques. Shakespeare has labelled this group as the cultural disability studies school.[81] Cultural disability scholars trouble the category of disability and focus on how representations of different ability attract socially constructed meaning. For example, Goodley analyses how disability becomes about discourse, not about abnormality.[82] Representations in society portray people as disabled and undesirable at one end of a spectrum and as hyper-capable and full economic citizens at the other.[83] Shildrick troubles and explores the attitudes of non-disabled people and the notion of able-bodiedness[84] and Campbell analyses how ableism in society manifests through the projection of 'perfect, species-typical' levels of ability.[85] A person who fails to meet those socially constructed standards of ability is constructed as disabled.

Another critical disability studies perspective is focused less on discourse and more on establishing a relational understanding of disability. Theorists in this school

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[73]Oliver (1990), p 11.
[74]Harpur (2013), pp 335, 529.
[75]Finkelstein (1980); Oliver (1994).
[76]Harpur (2012a), pp 1–14; see also Harpur (2012b).
[77]Fredman (2011), pp 171–173.
[78]Hacking (1999), p 14; Shakespeare (2014), p 60.
[79]Goodley et al (2012), p 1.
[80]Titchkosky and Michalko (2012), p 127.
[81]Shakespeare (2014), pp 49–55.
[82]Goodley (2001), pp 109, 207–231.
[83]Goodley (2014), Ch 9.
[84]Shildrick (2012), pp 30–41.
[85]Campbell (2009), p 5.

argue that the experiences of people with disabilities can only be understood through analysing the interaction between the individual and the environment (institutional, legal and societal factors). Shakespeare is one of the leading supporters of the interactional critical disabilities studies school, arguing for a more 'balanced approach to cure and therapy within disability studies'.[86] This approach accepts that, while society is a major factor in the construction of disability, medical factors can have a significant impact on how some people experience their impairments. For example, for a person with a wheelchair the built environment may play a major role in constructing their disability;[87] however, for a person who has advanced Huntington's disease their brain deterioration and loss of control over their voluntary movements may be a major factor in how they experience disability. Under this model, the concept of disability is recognised as 'so complex, so variable, so contingent, so situated. It sits at the intersection of biology and society and of agency and structure'.[88] Shakespeare has proposed an interactional model that explains how 'disability is always an interaction between individual and structural factors'.[89] Shakespeare's interactional approach explains that disability is understood by medical, psychological, environmental, economic and political factors.[90] The CRPD embraces this interactional understanding of disability and recognises that conceptions of disablement are influenced by both social and medical factors.[91] As will be seen in the next section, this intersectional approach to constructing disability is reflected in the duties that are placed over state signatories by the CRPD.

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What the CRPD requires of Australia

Similar to the CEDAW, the CRPD seeks to reverse historic inequalities and promote the rights of particular groups in society. The concept of 'equality' adopted in the CRPD can be understood through reflecting on models of disabilities. Following the trend set by the World Health Organization and World Bank,[92] the CRPD emphasises the role society has on disabling people. This position is most clearly articulated in the Preamble of the CRPD, where, in paragraph (e), the CRPD:

> Recogniz[es] that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

[86]Shakespeare (2014, p 153) refers to this approach as the 'critical realist school'.

[87]Clarke et al (2008).

[88]Shakespeare and Watson (2002), p 28; also quoted in Dowse et al (2009), p 37.

[89]Shakespeare (2014), pp 74–75.

[90]Shakespeare (2014), p 83.

[91]Harpur (2012a).

[92]The World Health Organization and World Bank (2011, p 3) adopt a biopsychosocial model of disability which acknowledges 'the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

While similar to social model scholarship, the CRPD Preamble explains that a key cause of disablement is barriers in society and, overall, it adopts an understanding of disablement that more closely reflects an understanding of disability found in the critical disability studies school. The CRPD considers a wide range of factors when conceptualising disablement, including healthcare, habilitation and rehabilitation, poverty and economic exclusion[93] and the impact of intersecting attributes, such as race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status.[94] The CRPD then takes this wide understanding of the concept of disablement and promotes equality through promoting a human rights paradigm.[95]

The CRPD includes disability specific human rights protections in Articles 3 to 9, which include universal rights, and Articles 10 to 30, which include substantive rights. These rights often restate existing rights, but some of the rights are included to ensure that well-established human rights can be realised. For example, while existing human rights conventions already explained that all people have a right to access justice, CRPD Article 13 restates that persons with disabilities have this right and then provides vehicles to ensure people with impairments can exercise this right (including reasonable accommodations and awareness training for law enforcement agencies). When analysing the rights in the CRPD, it is accordingly necessary to consider what rights exist in general human rights regimes, and then analyse how the CRPD interacts with these rights.

Prior to the CRPD, no United Nations human rights convention specifically dealt with domestic violence. To promote the rights of survivors, scholars have read other existing rights to include protection against domestic violence.[96] The CRPD does more than simply providing disability specific restatements of the rights to life,[97] liberty and security of the person,[98] freedom from torture or cruel, inhuman or degrading treatment or punishment,[99] protecting the integrity of the person,[100] the right to live independently and being included in the community,[101] respect for privacy,[102] and the right to adequate standards of living and social protection.[103]

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[93]Preamble (m).

[94]Preamble (p).

[95]Harpur (2011), p 1206; Harpur (2012a), pp 1–14.

[96]McQuigg (2011).

[97]Art 10.

[98]Art 14 and, in particular, Art 14(1) which explains that the ‘existence of a disability shall in no case justify a deprivation of liberty’.

[99]Art 15.

[100]Art 17.

[101]Art 1 and, in particular, Art 19(a): ‘Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement’.

[102]Art 22.

[103]Art 28.

The right in the CRPD that is most relevant to eliminating disability domestic violence is the right to be free from exploitation, violence and abuse.[104]

The right, encapsulated in Article 16, to be free from exploitation, violence and abuse, specifically includes protection from disability domestic violence. This right requires state parties to take all 'appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects'.[105] The inclusion of Article 16 is significant as, unlike the CEDAW, the CRPD contains an express recognition of the rights of people to live in an environment where there is no domestic violence. The CRPD goes further and explains how state signatories should adopt a multifaceted approach to ensure this right can be realised. To enable persons with disabilities to exercise this right, the CRPD explains that state parties must ensure, *inter alia*, appropriate forms of assistance and support for persons with disabilities and their families and caregivers, 'including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse'.[106] Where abuse does occur, the CRPD requires state signatories to have in place appropriate legislative frameworks 'to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted'.[107] As a bare minimum, the CRPD first requires state signatories to have laws on the books that criminalise disability domestic violence and, second, measures that ensure adequate enforcement of such laws. This article will now consider whether Australian laws are meeting the standard posited in the CRPD.

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Part III: How Australian laws respond to disability domestic violence

Limited application: the general criminal law

While criminal laws theoretically extend protection to persons with disabilities, similar to survivors without disabilities, criminal prosecution of domestic violence usually occurs only in the most extreme situations for both those with and without disabilities.[108] *R v Andrew* provides an example of how the criminal law has been applied to protect survivors with disabilities.[109] In *R v Andrew* the law did not proactively respond to prevent domestic violence. Rather, the criminal law 'protected' Brockie by retrospectively sanctioning the man that killed her.

In *R v Andrew*, the perpetrator, Andrew, pled guilty to the manslaughter of Brockie. Brockie, who had an intellectual disability, was unable to properly care for herself and relied on others to assist her. Andrew and Brockie had lived together as intimate partners for over 3 years. Andrew's relationship with Brockie was characterised by violence. In sentencing Andrew, Forrest J observed that there was:

[104]Art 16.

[105]Art 16(1).

[106]Art 16(2).

[107]Art 16(5).

[108]Nixon (2009), pp 77–89; Douglas (2012).

[109]*R v Andrew* [2008] VSC 138.

> […] a considerable body of evidence which demonstrates that for at least one year prior to her death you regularly assaulted [Brockie] to the extent that she was at times observed by others with apparent bruises on her legs and arms. [The perpetrator's] family and at least one medical practitioner all warned [him] that this behaviour was unacceptable.[110]

Despite the long term and serious nature of this violence the authorities did not become involved with this situation until the survivor was violently beaten to death, which led to the perpetrator being convicted of manslaughter. *R v Andrew* suggests an inattentive at best, and negligent at worst, approach by law enforcement agencies in this case who only became involved in the situation of domestic violence when the violence had escalated to a tragic and fatal level. It is probable that the delay in intervention was exacerbated because Brockie relied on her abuser for assistance with daily tasks. While in these circumstances she may have been particularly reluctant to call for police intervention or give evidence against her abuser,[111] there are deeper systemic issues of discrimination and de-authorisation at play for women with disabilities. Researchers have observed that women with disabilities are often stereotyped as dependent and asexual and likely to be devalued in society, and these views compromise the ability of service providers to recognise the seriousness of abuse and on the willingness of police to pursue complaints.[112] Such attitudes clearly have implications for criminal justice responses as women with disabilities are unlikely to receive adequate support to give statements and evidence, and without appropriate support they may be perceived as unreliable. Furthermore, research suggests that women with disabilities may be more likely than others to blame themselves for the abuse or to believe they are deserving of it.[113] These attitudes may also be an obstacle to naming the abuse as domestic violence or criminal assault and to seeking assistance.

Even where the criminal law recognises that certain groups are especially vulnerable, such laws have limited application in domestic settings. Persons with intellectual disabilities are especially vulnerable to exploitation.[114] The criminal law recognises this enhanced vulnerability to some extent and has introduced limited protections. Some examples are discussed further below.

Sexual assault and other sexually abusive behaviour is a common aspect of domestic violence.[115] Proving lack of consent is a key aspect of all sexual offences. Both disclosure of the abuse and proving lack of consent may be particularly difficult in cases where persons with disabilities are sexually assaulted. In cases where sexual abuse is perpetrated by a carer, or a person in authority is responsible for the abuse, people with disabilities have a 'double vulnerability' and may be particularly

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[110] *R v Andrew* [2008] VSC 138, at 14.
[111] NSW LRC (1994), para 7.42.
[112] Curry et al (2001), p 61.
[113] Curry et al (2001), p 61; Martin et al (2006), p 824.
[114] Dowse et al (2009); Robinson (2013), p 14.
[115] Brownridge (2006), p 806; Martin et al (2006); NCRVWC (2009), p 9.

reluctant to disclose the abuse because of their dependence on the abuser.[116] Research suggests that if people with a disability do disclose sexual abuse they are regularly not believed or blamed for the assault.[117]

Law makers recognise the particular vulnerability of persons with a cognitive disability,[118] and have amended criminal laws to increase protection for this group in largely non-domestic situations. Except for the Australian Capital Territory, the criminal laws in all Australian jurisdictions create a presumption of lack of consent through prohibiting people from having sexual intercourse with a person who has a cognitive impairment in a range of situations.[119] The Commonwealth statute limits the offence to children with mental impairments [120] and the Victorian statute limits the offence only to providers of medical or therapeutic services or their workers.[121] These laws do not prevent people with mental disabilities from expressing their sexuality, but provide people additional protection when they are exploited.

The presumption against consent may provide persons with cognitive disabilities some protection.[122] However, these protections have very little application in domestic relationships. The presumption does not apply if the parties are married or *de facto* in New South Wales,[123] married or in a significant relationship in Tasmania,[124] married or domestic partner in Victoria,[125] or married in Western Australia.[126] The presumption pertaining to a lack of consent can also be rebutted in Queensland and Tasmania if the conduct is not exploitative.[127] Without the presumption, persons with cognitive disabilities are protected by the standard criminal laws that apply to all survivors. Evidence demonstrates that the criminal

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[116]Keilty and Connelly (2001), p 273; Bartlett and Mears (2011), p 10; Murray and Heenan (2012), p 352.

[117]Bartlett and Mears (2011), pp 64–65.

[118]See Baldry et al (2013) for a consideration of cognitive disability and vulnerability to harm.

[119]How the impairment is described differs across jurisdictions: *Criminal Code Act 1995* (Cth), Schedule s 272.10 uses the term 'mental impairment'; *Crimes Act 1900* (NSW), s 66F uses the term 'cognitive impairment'; *Criminal Code Act 1983* (NT), Schedule 1 s 130 uses the term 'mentally ill or handicapped person'; *Criminal Code 1899* (Qld), s 216 uses the term 'persons with an impairment of the mind'; *Criminal Law Consolidation Act 1935* (SA), s 5AA uses the term 'persons with an impairment of the mind'; *Criminal Code Act 1924* (Tas), Schedule 1 s 126 uses the term 'mental impairment'; *Crimes Act 1958* (Vic), ss 51 and 52 uses the term 'persons with a cognitive impairment'; *Criminal Code Act Compilation Act 1913* (WA), Appendix B, s 330 uses the term 'person who is … mentally impaired'.

[120]*Criminal Code Act 1995* (Cth), Schedule s 272.10.

[121]*Crimes Act 1958* (Vic), ss 51 and 52.

[122]For examples of where these provisions have been used to convict people for exploiting persons with mental disabilities, see *Bennell v The State of Western Australia* [2011] WASCA 174; *R v Raphael* [2009] QCA 145.

[123]*Crimes Act 1900* (NSW), s 66f(7)(ii).

[124]*Criminal Code Act 1924* (Tas), s 126(2)(b).

[125]*Crimes Act 1958* (Vic), ss 51, 52.

[126]*Criminal Code Act Compilation Act 1913* (WA), Appendix B, s 330(9); *Domestic Violence and Protection Orders Act 2008* (ACT), ss 13, 14.

[127]*Criminal Code 1899* (Qld), s 216(4)(d).

law generally affords survivors without disabilities limited protection.[128] Arguably, survivors with disabilities enjoy even less protection.

How domestic violence laws protect survivors with disabilities

Throughout the 1980s domestic violence statutes were introduced in all Australian states.[129] Under these statutory regimes civil protection orders can be made by lower courts that include conditions which prohibit a perpetrator who has committed acts of domestic violence from committing further acts of violence against another identified person. Breaches of protection orders can result in criminal charges and sanctions. As observed earlier, some forms of violence experienced by survivors are common to people both with and without disabilities. This part is only concerned with forms of violence that are aggravated or unique to survivors with disabilities. To obtain protection under domestic violence statutes, a survivor must first establish that the abuse they have experienced satisfies the legal definition of domestic violence.[130] There has been significant debate about the appropriate definition for domestic violence. The diversity of definitions throughout Australia was highlighted as a concern by a recent report of the Australian Law Reform Commission, which recommended a common interpretive framework throughout Australia that was gender neutral and focused on the context of domestic violence.[131]

Most forms of disability domestic violence can be defined as domestic violence under the relevant statute in each jurisdiction. To ensure survivors with particular vulnerabilities are protected, some statutes provide specific examples of what constitutes domestic violence. As discussed above in this article, threats of institutionalisation, violence to service animals and interference with medical treatment are three such examples that are particularly relevant to survivors with disabilities.

Unlike all other jurisdictions, the South Australian statute expressly includes threats to institutionalise a survivor as emotional abuse and domestic violence.[132] Arguably, the inclusion of this threat recognises the significant fear in the disability and elderly communities about the perception of how they would be treated in institutions.[133] Most Australian domestic violence statutes regard violence against pets as domestic violence. The statutes in the Australian Capital Territory, Northern Territory, Queensland, South Australia and Western Australia specifically regard violence against pets as domestic violence, so service animals would be

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[128]See, for example, Attorney General's Department (SA) (2014).

[129]See, generally, Wilcox (2010).

[130]*Domestic Violence and Protection Orders Act 2008* (ACT), ss 13, 14; *Crimes (Domestic and Personal Violence) Act 2007* (NSW), ss 4, 7, 19; *Domestic and Family Violence Act 2007* (NT), ss 5–,7; *Domestic and Family Violence Protection Act 2012* (Qld), ss 8, 11, 12; *Intervention Orders (Prevention of Abuse) Act 2009* (SA), s 8; *Family Violence Act 2004* (Tas), ss 7, 8; *Family Violence Protection Act 2008* (Vic), ss 5–7; *Restraining Orders Act 1997* (WA), s 6.

[131]Australian Law Reform Commission (2010), pp 234–235.

[132]*Intervention Orders (Prevention of Abuse) Act 2009* (SA), s 8(4)(n).

[133]Pyke (2007), p 9.

covered here.[134] Access to medication is critically important to persons with certain disabilities.[135] Indeed, access to medication can be the difference between extreme agony and comfort, between further disablement and increasing morbidities, between life and death. The Queensland, South Australian and Victorian statutes expressly identify interference or threatening to refuse medical treatment as domestic violence.[136]

The particularisation of specific actions that come within the definition of domestic violence may be helpful for those seeking redress or exercising powers under domestic violence protection legislation. However, this level of specificity is not essential to ensure survivors with disabilities receive protection from domestic violence. The United Nations has recommended that domestic violence legislation 'should include a comprehensive definition of domestic violence, including physical, sexual, psychological and economic violence'.[137] In its review of domestic violence laws in Australia, the Australian Law Reform Commission (ALRC) was of the view that context was also an important aspect of defining domestic violence.[138] The ALRC recommended that 'family violence should be defined in state and territory family violence legislation as violent or threatening behaviour or any other form of behaviour that coerces or controls a family member or causes that family member to be fearful'.[139] This approach is reflected in both Queensland and Victoria.[140] While the domestic violence statutes in both Queensland and Victoria also contain numerous examples of domestic violence, the broad definition, encapsulating coercion and control, ensures that new or unusual forms of domestic violence could come within the definition.

Similar to all survivors, survivors with disabilities can experience physical violence and damage to their property; however, a significant amount of disability domestic violence may be emotional or psychological abuse.[141] In relation to emotional abuse, context may be very important in understanding why a particular comment or action is emotionally or psychologically abusive. Thus, the introduction of context into the definition of domestic violence, as recommended by the ALRC, may be particularly helpful for those experiencing disability domestic violence which is emotional or psychological in nature.

The wide ambit of what constitutes emotional harm or intimidation means that most forms of disability domestic violence could come within this definition. Emotional harm or intimidation might include the denial of disability by the abuser,

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[134] See, for example, *Domestic and Family Violence Protection Act 2012* (Qld), s 8(2)(g).

[135] WWDA (2007), pp 198, 239.

[136] See, for example, *Domestic and Family Violence Protection Act 2012* (Qld), s 11; *Intervention Orders (Prevention of Abuse) Act 2009* (SA), s8(4)(m); *Family Violence Protection Act 2008* (Vic), s7.

[137] UN DESA/DAW (2009), para 3.4.2.1.

[138] Australian Law Reform Commission (2010), p 234.

[139] Australian Law Reform Commission (2010), p 234. This is now the approach in Victoria and Queensland: *Family Violence Protection Act 2008* (Vic), s5(1); *Domestic and Family Violence Protection Act 2012* (Qld), s8(1).

[140] *Domestic and Family Violence Protection Act 2012* (Qld), s 8(1); *Family Violence Protection Act 2008* (Vic), s5(1).

[141] WWDA (2007).

ignoring requests for assistance and withholding or altering aids.[142] If an assistive device, such as a wheelchair, is hidden or pushed out of reach of a survivor, then that survivor most likely will be prevented from moving around or leaving their home, and this may be interpreted as emotional harm or intimidation. No domestic violence statute specifically deems this form of violence as constituting domestic violence; however, the psychological trauma caused by such conduct, being both a coercive and controlling action, would bring this conduct within the Queensland and Victorian definition of domestic violence. Furthermore, domestic violence statutes in all jurisdictions regard emotional abuse, intimidation or psychological harm as domestic violence, even where such conduct is not associated with physical or property damage.

In conclusion, most forms of disability domestic violence come within legislative definitions of domestic violence. However, to meet the standard posited in the CRPD, Australia needs to do more than just ensure there are protections on the books. Australia needs to ensure these laws are adequately enforced. Part IV argues that Australia is failing to enable survivors with disabilities to turn domestic violence legal protections into practical support.

Part IV: Where domestic violence laws fall down: implementation and enforcement

The available evidence suggests that domestic violence laws are not adequately protecting survivors with disabilities.[143] Applications for domestic violence orders are heard in the magistrates courts and the proceedings are rarely reported; accordingly, it is difficult to obtain transcripts of hearings and judgments.[144] In addition to the difficulties in accessing magistrates courts' judgments, in the domestic violence jurisdiction there are often express restrictions on publishing proceedings.[145] While confidentiality is critical for survivors, this creates difficulties in evaluating the effectiveness of laws. Despite this limitation, evidence presented in this article suggests that survivors with disabilities encounter substantial barriers both with calling for help and in having legal institutions take their calls for help seriously.

Impairment as an impediment to survivors with disabilities seeking help

Australia has an obligation under the CRPD to provide additional support to enable persons with disabilities to access sources of help. This section argues that current services are inadequate. Authorities must be made aware of a domestic violence

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[142] WWDA (2007).

[143] Plummer and Findley (2012); Healey et al (2013), pp 50–68.

[144] *Crimes (Domestic and Personal Violence) Act 2007* (NSW), ss 3 and 72 (Local Court or Childrens Court); *Domestic and Family Violence Act 2007* (NT), ss 4 and 30 (Court of Summary Jurisdiction); *Domestic and Family Violence Protection Act 2012* (Qld), s 32 (Magistrates Court); *Domestic Violence and Protection Orders Act 2008* (ACT), s 18 (Magistrates Court); *Family Violence Act 2004* (Tas), s 30 (Magistrates Court); *Family Violence Protection Act 2008* (Vic), s 42 (Magistrates Court or Childrens Court); *Intervention Orders (Prevention of Abuse) Act 2009* (SA), ss 3 and 20 (Magistrates Court); *Restraining Orders Act 1997* (WA), ss 5 and 25 (Magistrates Court or Childrens Court).

[145] See, for example, *Family Violence Protection Act 2008* (Vic), s 166.

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situation before they can enliven legal protections. While reporting abuse is a problem for all survivors, persons with disabilities confront particular difficulties which further reduce the probability that their experience will be communicated to, or recognised by, authorities and acted upon in the courts.[146] People with certain disabilities may encounter particular barriers to making the call for help, travelling to the police station or accessing a service without support. As noted earlier, survivors with disabilities can be dependent upon the perpetrator to assist them to leave the house or to communicate with outsiders. Research indicates that there are not sufficient services available to those fleeing domestic violence and many mainstream services are ill-equipped to support people who have a disability.[147]

Evidence suggests that implementation of domestic violence legislation by police has been inconsistent at best.[148] Some studies suggest that police often accept the male perpetrator's version of events, misinterpret signs of violence, and are slow to respond to the entreaties for help from the survivor.[149] The discounting of a survivor's voice may be intensified in disability domestic violence situations. While police wanting to question a suspect of crime who has 'impaired capacity' must ensure the suspect has a support person present,[150] there is generally no similar requirement when police are talking with a victim of crime, such as a survivor. A victim who has a disability may find it difficult to communicate with a police officer without support. Furthermore, an apparently rational and highly articulate abuser could be more likely to be believed and considered more reliable[151] in comparison to a survivor who has difficulty communicating their story to the police.

The gap between approaches to enforcement and the human rights standard in the CRPD

The CRPD requires Australia 'to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'.[152] This requires Australia to take active steps to alter customs and practices that are based upon outdated paradigms which prevent survivors with disabilities from exercising their right to be free from violence in the home. Evidence suggests that prejudice against survivors with disabilities remains a significant barrier to their capacity to obtain protection and justice.

Despite the existence of the CRPD and public policy models that construct persons with disabilities as citizens entitled to exercise all their human rights, many in the community hold different views. An extreme reaction to persons with

[146]Chenoweth and Cook (2001), p 4; Mays (2006).

[147]PWDA, 'Stop the Abuse', http://www.pwd.org.au/pwda-publications/stop-the-abuse.html. 17 January 2015.

[148]Crime and Misconduct Commission (2005); Douglas and Fitzgerald (2013).

[149]See Websdale and Johnson (1997), p 297; Douglas and Stark (2010), pp 44–53.

[150]See, for example, *Police Powers and Responsibilities Act 2000* (Qld), s 422.

[151]PWDA, 'Stop the Abuse', http://www.pwd.org.au/pwda-publications/stop-the-abuse.html. 17 January 2015.

[152]Art 4(1)(b).

disabilities is hatred and disgust.[153] A far more common reaction is one of charity, pity and devaluing the voice of persons with disabilities.[154] Leading social model scholars, Mike Oliver and Colin Barnes, argue that the individual and tragic constructions of disablement continue to remain dominant in almost all policy and political discussions.[155]

Under the medical model, medical professionals construct themselves as the gatekeepers of what constitutes a normal ability and when a person's ability means they are characterised as abnormal.[156] If a person's ability does not meet the medically constructed standard of normality, then under this model the person is regarded as defective and often excluded from mainstream culture.[157] Under the medical model, a person with a disability is constructed as a patient that has reduced capacity and may require their affairs be managed on their behalf. The medical model, and its problematising of disability, continues to influence public policy debates in the twenty-first century.[158]

The medicalisation and problematising of disability is reflected in how laws approach domestic relationships between people with disabilities and a person that provides care. All jurisdictions in Australia provide special regulatory protection to people who provide unpaid caring support to another.[159] These regimes seek to protect and recognise the valuable charitable work performed by unpaid carers. The operation of these laws can be illustrated by analysing the relevant Queensland regime. The *Carers (Recognition) Act 2008* (Qld) s 4 explains that:

> […] the objects of this Act are—
> (a) to recognise the valuable contribution by carers to the people they care for; and
> (b) to recognise the benefit, including the social and economic benefit, provided by carers to the community; and
> (c) to provide for the interests of carers to be considered in decisions about the provision of services that impact on the role of carers …

Furthermore, the Queensland Carers Charter states:

> […] the Parliament recognises that carers make a significant contribution to the people they care for and the economic and social wellbeing of the community, and that carers deserve recognition, respect and support for their role as carers.[160]

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[153] Sherry (2010); this book provides the example of the sexual exploitation and video taping of a disabled girl in Melbourne, Australia in 2006. The perpetrators all avoided jail (Smith 2011).

[154] Sin (2013); Shakespeare (2014), p 233.

[155] Oliver and Barnes (2012), p 14.

[156] Waddington and Diller (2002), pp 241–244.

[157] Stein and Stein (2007), p 1206; see also Stein et al (2012).

[158] Rees et al (2008), p 249.

[159] *Carer Recognition Act 2010* (Cth); *Carers (Recognition) Act 2010* (NSW); *Carers Recognition Act 2009* (NT); *Carers (Recognition) Act 2008* (Qld); *Carers Recognition Act 2005* (SA); *Carers Recognition Act 2012* (Vic); *Carers Recognition Act 2004* (WA).

[160] *Carers (Recognition) Act 2008* (Qld), Schedule: The Queensland Carers Charter.

These statutes and charters construct carers as valuable members of the healthcare system and who should have a voice in regulating the provision of care. While carers do play an important role in the community, it is curious that these regimes do not provide avenues that enable recipients of care to have their voices heard in discussions pertaining to how such care is regulated. As a consequence, persons with disabilities tend to be cast as passive recipients of care and support.

The construction of disability as a medical problem, which requires support from medical staff and carers, may have negative implications for survivors with disabilities who are reaching out to authorities for help. Persons with disabilities are often particularly reliant on the police and other support agencies to help them escape the violence. Some survivors with disabilities have reported that services have been unable or unwilling to provide help to them because of their impairments.[161] A person's perception of the domestic relationship as a primarily carer relationship, due to the existence of a disability, may create barriers for the survivor accessing support.[162] For example, people who help persons with disabilities have been regarded as charitable and are clothed with the authority associated with their medical status of carers.[163] When a person with a disability partners someone who does not have a disability, the relationship is sometimes referred to as a 'Florence Nightingale marriage'.[164] In such a union, one spouse is constructed as a therapeutic attendant and the other spouse, who has a disability, as the patient. While the relationship may involve therapeutic assistance, the actual or perceived need for a therapeutic relationship may overshadow the existence of a loving relationship in the minds of authorities. Such a partnership may be cast permanently as something different. This difference may be disempowering and even dangerous if the survivor with a disability decides to approach authorities about abuse. In the words of a survivor with a disability:

> People pity him because he is taking care of you … people are reluctant to criticise this saint or to think he could be doing these terrible things. And possibly as well … people don't really 'see' a disabled woman as a wife, partner, and mother. So I think for some people it's hard to think well this might be a woman who's being sexually or physically abused by her partner, is experiencing domestic violence because disabled women don't have sex, do they?[165]

Where a survivor's abuser is also their carer, survivors may have their rights discounted and their capacity to access justice denied. Some of those with a disability who are abused may also develop a similar view of themselves as lucky to be cared for by the abuser, as deserving of abuse or as responsible in some way for the abuse, and these views may obstruct their own help-seeking actions.[166]

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[161]Thiara et al (2012), pp 16, 17, 56–60.

[162]This also occurs when elderly people who are disabled are abused by carers and family: Nerenberg (2008), Ch 1.

[163]Nixon (2009). For a discussion of how the creation of oppressed groups often results in the creation of privileged groups, see Pease (2010), p 5.

[164]Gordon (1997), p 202.

[165]Hague et al (2011).

[166]Curry et al (2001).

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Impact of implementation and enforcement problems

In his analysis of perpetrator-related characteristics, Brownridge identifies a number of reasons for perpetrators to abuse an intimate partner who has a disability. He identifies the association between violence against women and patriarchal domination and suggests that some men may see women with a disability as easier to dominate or control.[167] He also points to some abuser's need to assert sexual propriety over a partner, and to the possibility that many carers may be stressed and that this stress may explain their violence towards an intimate partner with a disability who they care for.[168] Others suggest that perpetrators of abuse can draw on the discourse of natural entitlement associated with the medical model that constructs persons with disabilities as in need of care.[169] Perpetrators may construct a public identity of a caring and loving person. The fact the perpetrator showers the survivor, manages the survivor's finances for them, is the survivor's driver and takes them to all their medical appointments means that the perpetrator has almost total control over the survivor's life. If that perpetrator is also engaging in physical and sexual violence, who will listen to the survivor?[170] Instead of identifying the abuser as a perpetrator, authorities may construct the perpetrator as a hero and may be more willing to listen to the perpetrator's voice. The fact survivors with disabilities are often unable or unwilling to report violence, and regularly not believed if they do, make them at heightened risk of being targeted by perpetrators.[171]

Conclusion and recommendations

Survivors with disabilities experience domestic violence more frequently and differently from the wider survivor population. Survivors with disabilities often rely upon perpetrators for assistance with daily tasks, making it more difficult for them to seek help. As analysed in Part I of this article, some perpetrators reportedly use survivors' impairments to intensify domestic violence (such as threats of institutionalisation) and use disability specific forms of violence (such as interfering with mobility aids). The CRPD recognises the vulnerability of survivors with disabilities and imposes international law obligations on Australia to provide legislative responses that criminalise disability domestic violence and to put measures in place that ensure adequate enforcement of such laws.

In some jurisdictions Australian laws provide persons with disabilities with insufficient protection from domestic violence. As analysed in Part III of this article, domestic violence statutes adopt several mechanisms to protect survivors with disabilities. Approaches include defining domestic violence broadly as behaviour that is coercive and controlling, specifically identifying and prohibiting forms of disability specific violence and providing broad protections for intimidation,

[167]Brownridge (2006), p 809.

[168]Brownridge (2006), p 809.

[169]For a discussion of how men use the discourse of natural entitlement to reinforce their dominance over women and to legitimise gender violence, see Adams et al (1995).

[170]For a discussion of how support services frequently overlook or respond inappropriately to survivors with disabilities, see Hague et al (2011).

[171]Lund (2012).

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harassment and emotional abuse. While Victoria and Queensland have introduced concepts of coerciveness and controlling behaviour into their definitions in domestic violence statutes, we suggest that law makers in other states should adopt the ALRC's recommendations and should ensure the definitions of domestic violence identify that coercion and control lie at the heart of domestic violence. While identifying specific abuse behaviours is helpful, a definition centred on coercion and control may help to ensure that disability domestic violence is better recognised, responded to, prosecuted and ultimately reduced.

Despite the recent adoption of the CRPD by Australia, and the acceptance that persons with disabilities should be able to exercise their human rights on an equal basis as others, many in the community continue to hold on to outdated models of disability. As analysed in Part IV, outdated assumptions can confound the operation of domestic violence laws. Medical understandings of disability construct disability as a problem and the person with a disability as being in need of medical care. When this model is applied to domestic relationships, the person with a disability may be constructed as a patient without a voice and their violent partner may be constructed as a heroic and charitable therapeutic attendant. Within that paradigm, survivors with disabilities who try to make contact with authorities have found their voices are ignored.

As with other forms of domestic violence[172] it is argued here that implementation and enforcement problems are the primary barrier preventing survivors with disabilities from accessing domestic violence legal protections. Research suggests that integrated approaches, including responses through education, health and law, are required to combat domestic violence.[173] Within an integrated approach, the justice system is just one aspect.[174] An additional avenue to improve response and enforcement would be to improve community based support services.[175] We argue that an important step in developing better responses to, and reducing the prevalence of, disability domestic violence is to promote the human rights paradigm in the CRPD and to provide community groups with sufficient resources to enable them to provide services that enable survivors with disabilities to exercise their human rights.[176] In line with the critical disability studies approach, it is important to challenge stereotypes about disability which might continue to inform how legal service providers, police and courts respond or fail to respond to violence against people with a disability. While there is no simple solution to resolve the complicated problem of disability domestic violence, there are a range of measures that are available to better enable persons with disabilities to exercise their human right to live free from domestic violence.

[172]Hunter (2006).

[173]Pyke (2007).

[174]Victorian Law Reform Commission (2006), para 3.53.

[175]Attorney-General's Department (SA) (2014), p 6, stating: 'Promoting awareness and understanding among service providers and the broader community has been shown to enhance the rights of people with disability'.

[176]Walter-Brice et al (2012).

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