

# VOICES

**People with an Intellectual Disability  
and  
Victims of Crime**

***PART A:  
Preventing Crime, Abuse and Exploitation  
within Services***

***PART B:  
Healing and Moving On***

*A Victims of Crime Project, jointly sponsored by Alina Families Program, Community Living Association, and WWILD-SVP Service.  
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We thank all Project participants for their willingness to give time and thought to the VOICES interviews, workshops and consultations. We thank them, too, for their commitment to help prevent crime, abuse and exploitation against people with learning difficulties and to support victims of crime to move on and, with healing, become survivors.

Sandra Sewell, Project worker

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# The VOICES Project

## Origins of the VOICES Project

People with learning difficulties are more likely to be victims of physical and sexual assault, theft, fraud, exploitation, abuse and neglect than people without learning difficulties (Chenoweth, 1993; Wallis Consulting Group, 1996; WWILD-SVP, 1999; Dept. Families, Youth and Community Care, 1999). They are, however, less likely than others to report a crime or abuse and, if they do, to be believed and gain justice and recompense (Williams, 1999; Johnson et al, 1988).

People with learning difficulties are vulnerable to victimisation because they are likely to be socially isolated, dependent on carers, not taken seriously, unable to frame or unwilling to register a complaint, and unable to access relevant agencies (Aiello, 1986, Conway et al, 1996). Importantly, they may also lack understanding or knowledge of their rights (Williams, 1999; Community Living Program, 1998; Eastwell and Cheyne, 1997). Further, they may experience multiple episodes and forms of victimisation, abuse and exploitation, and the road to recovery and healing can be long and hard.

It was these kinds of realities that, four years ago, brought together workers from Alina Families Program, Community Living Association and WWILD-Sexual Violence Prevention Service in Brisbane North to share their concerns and their practice experiences with regard to constituents who are alleged victims, witnesses, and, to a lesser extent, alleged offenders of crimes.

The workers wanted to develop organisational policies and procedures to guide staff in assisting people with learning difficulties through the complexities of police, legal and court processes. In the course of that work, it became clear that there was need for a lot more information and training materials than were currently available to disability workers, carers and families.

The three organisations applied for and gained Victims of Crime funding from Queensland Department of Justice which enabled them to appoint a part-time project worker for 12 months, supported by a Reference Group with members from the participating organisations.

**NOTE:** *We use the term 'learning difficulties' instead of the term "intellectual disability. We do this because it seems to be the preferred self-description of the people with whom we work. These terms may be used interchangeably throughout the report.*

The focus of the first phase of the VOICES Project (1998-1999) was on assisting people to report a crime and to pursue their rights for justice through police, legal and court processes. The Project Team developed a Workbook, "People with an Intellectual Disability and the Criminal Justice System" (available from Community Living Association), which we took out to five practitioner workshops around south east Queensland, seeking advice and comment. We later hosted a Conference so that colleagues in disability services, in government and in universities could share practice wisdom. Conference delegates endorsed a number of action recommendations that have been forwarded to government departments and relevant groups, and followed up with meetings and delegations.

During the first phase of the Project, we often heard workers express their concerns about the difficulties of dealing with crime, abuse and exploitation of people with learning difficulties within services (between workers and constituents, and between constituents), and their concerns about how best to help people recover from the trauma and move on in their lives. The Reference Group applied for and gained further funding to research these concerns and to develop materials to assist workers. This document is the outcome of that work.

## **Methodology**

In this second phase of the VOICES Project, we have gathered information and advice both from the literature and from interviews and workshops with a range of workers, within and without the disability sector.

### **Literature**

The most relevant material we have been able to find in the literature is recorded in Appendix 5 to Part A and in Appendix 3 to Part B.

The focus of literature on within service abuse is often on sexual abuse, primarily abuse perpetrated on young women with learning difficulties, but with increasing attention to male sexual abuse as well. There is comparatively little literature on other more everyday, but also traumatising, forms of abuse, such as financial exploitation in the form of fraud, theft, robbery with assault, and verbal abuse, for example, insults and name calling, (Tichon, 1998; Law Reform Commission of NSW, 1992, 1993). Similarly, there is more attention in the literature to abuse that occurs between workers and constituents than to abuse that occurs between constituents.

The focus of literature on post trauma support and counselling is primarily on diagnosis and therapy. Post trauma counselling is a field of work in its own right, and the scope of the work takes in survivors of war, torture, and natural disasters as well as survivors of domestic violence and victims of assault. We have found only a few articles that directly address post trauma support for people with learning difficulties. However, because we believe people with learning difficulties are likely to be

especially vulnerable to chronic stress illnesses, including Posttraumatic Stress Disorder (PTSD), we have drawn from the literature some of the insights and techniques of the trauma counselling field that may be helpful to people with learning difficulties.

### **Interviews**

To gather the practice experiences and advice of workers (for both Part A and Part B of the Project), we have sought and recorded interviews with a range of practitioners. Most interviewees have been people with expertise and experience in the disability field: those who have not had this background have been invited to contribute their particular knowledge and skills, for example, in trauma counselling or industrial relations or workplace health and safety.

The interview questions on within service abuse were: "Can you tell us what experiences you have had in your practice of within service abuse?" "In retrospect, what would you do differently now?" "What do you think are the key elements of prevention of within service abuse?"

The interview questions for post trauma support varied according to the background of the interviewee, but encompassed requests for advice on what has proved helpful for people (especially people with learning difficulties) who have experienced trauma, and worker's views on differing approaches and techniques (for example, group work and/or individual work, re-experiencing the trauma and/or moving ahead).

### **Workshops**

Following the individual interviews, we summarised the interview materials and either circulated them to invited workshop participants prior to the workshop or presented the materials verbally at the workshop.

The workshop we hosted on within service abuse was attended by Project interviewees. In a half day facilitated forum, we asked participants to comment on the draft summary of the interviews (forwarded in advance) and, in particular, on the materials in the draft summary on prevention.

The workshop we hosted on post trauma support brought together practitioners, including trauma counsellors, youth workers, and disability workers. In a half day facilitated forum, we tested emerging frameworks for practice, with explicit reference to past and current issues disability workers faced in their practice. Following this workshop, a draft of Part B of this Report was forwarded to members of the Reference Group and to trauma counsellors for their comments.

### **Write Up and Distribution of Report**

Having incorporated readers' comments, we finalised the Report which will be distributed to all participants, as well as to relevant government officers, peak bodies, and individuals. Additional copies of the Report are available from Community Living Association.

## Outcomes

We hope that this Report will be a helpful resource for workers, carers and families, and a training and induction aid for community-based disability organisations.

In a less tangible way, the outcomes of the Project have been an enhanced awareness and knowledge amongst disability workers of within service abuse and of post trauma support. There have already been, during the life of the Project, useful consultations and referrals amongst participants, and increased knowledge of the expertise and resources available to workers in what are extremely difficult practice situations. There has also been some cross-fertilisation of ideas and new relationships formed between, for example, the trauma counselling field, the police, the union, and the disability field.

# PART A

## PREVENTING CRIME, ABUSE AND EXPLOITATION WITHIN SERVICES

*The poverty of people with disabilities means that they may lack the resources - let alone the physical ability - to leave abusive situations. Some people have no ideas about their right not to be treated in abusive ways. Many are taught to be passive and compliant to make the care-giving task easier, also making the process of victimization easier. Many have developed low self-esteem as a result of social messages about their worth as human beings. Many people with disabilities are isolated and segregated in institutional settings. Many are dependent on others for help with - and as a result lack control over - the most basic of daily living activities ... Some people are unable to communicate in traditional ways. Care-givers are often over-worked and frustrated, lacking sufficient resources and time to provide proper care." (Rueher Institute, 1995, i)*

*Abuse between constituents has included domestic violence between married couples, third party exploitation, and sexual assaults in shared households. It is complex - sometimes the exploiter may not understand that their behaviour is exploitive, and sometimes the victim does not want anything to happen in case it fractures their relationship with the perpetrator. They may say, "I just want him/her to say sorry". (Interviewee)*

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## 1. NATURE, RANGE AND COMPLEXITIES OF ISSUES

Crime, abuse and exploitation within services for people with learning difficulties are violations of trust and vulnerability and violations of people's human rights.

How do we define 'abuse' and what types of abuse occur? Sobsey (1994) defines abuse as: "Behaviour towards another person that is unwanted, demeaning, dehumanising, or degrading. ... The general term abuse is used to span the spectrum from mild infractions to serious criminal acts against people of all ages." Brown and Mirenda (1997) define abuse, following the Canadian Adult Guardianship legislation, as "deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm; or (b) damage to or loss of assets; and includes intimidation, humiliation, physical assault, sexual assault, over-medication, withholding needed medication, censoring mail, invasion or denial of privacy, or denial of access to visitors". Williams (1995), in a review of journal articles and publications, has identified eleven types of abuse against people with learning difficulties: sexual abuse and assault, neglect, behaviour management abuse, physical abuse and neglect, emotional/psychological abuse and neglect, financial abuse/theft, verbal abuse, institutional abuse, violation of rights, lack of choice, and malnutrition.

Whatever the definition or type of abuse, the victim suffers loss and trauma - in situations where the abuse occurs between a worker and a constituent, in situations where abuse occurs between constituents, and in situations out in the community where members of the public abuse demean or otherwise abuse people with learning difficulties.

It is difficult to estimate the incidence of abuse in general and within services in particular (Dept. Families, Youth and Community Care, 1999). Sobsey (1994), reporting on a number of studies, concludes that there is little agreement about the rates of abuse within services, either by care-givers or by peers with disabilities. While accurate statistics of within service abuse would be very useful in substantiating what is largely anecdotal evidence, that task was beyond the scope of this Project. People were invited to be interviewed for the Project on the basis of their practice experience in the area, and particularly for their views on what is needed within services to prevent abuse. Most had seen incidences of alleged abuse, with varying organisational responses to the alleged victims and the alleged perpetrators. Most believed that, while it is impossible to guarantee that abuse will never occur within services, there is much that can be done to enhance prevention.

Why and where does abuse occur, and who are the perpetrators? Sobsey (1994) has developed an "integrated ecological model of abuse" to explain how culture, environment and power relationships pre-dispose people with learning difficulties to abuse from others (160). Brown and Mirenda (1997) have this to say: "As yet, there hasn't been a comprehensive study focusing on abusers ... Most abuse happens where a person lives: a private residence, a group home or other type of community facility. However, people with developmental disabilities are also vulnerable in parks,

recreation centres, professional offices, day activity centres, schools, hospitals, buses, taxis, and other places and community settings - in short, anywhere! Most individuals are abused by someone they know ... In many cases, the offender is someone who is depended on for daily care and support: a care-giver, a parent, a relative, a friend. However, offenders can also be community members, professionals, teachers, neighbours, acquaintances, and other people with disabilities - in short, anyone!" (8).

Interviewees in this Project agreed. They commented that "abuse will always be there, in different forms and at different levels," because "people with intellectual disability are always exposed to exploitation" - from institutions, systems, peers, family, carers, service staff, and the general public - and because "people with intellectual disability seem to have to endure greater harm [than others] before something is done". Some were hopeful that, within organisations, "the level of scrutiny has increased - we catch it at a lower level". Others believed that the disability sector is isolated from the mainstream community service sector and, "with a lot of sole workers, our organisations are always going to be at risk". As well, negative community attitudes, such as "bad things happen to bad people" or "no one would commit a violent act toward a disabled person because everyone feels pity toward a disabled person" (Aiello, 1983), play a large part in perpetuating 'tolerance' of abuse against people with learning difficulties.

Interviewees had mixed views about perpetrators: "most perpetrators have been married men"; "there is no one type of perpetrator and no one type across different forms of abuse"; "there are two kinds of perpetrators - those who are plain 'evil' and those who 'lose it'". Certainly, we heard chilling stories of premeditated, calculated abuse perpetrated on vulnerable people with learning difficulties. We also heard stories of unproven abuse, of suspected abuse, and of abuse resulting from poor selection, training and supervision of staff. The perpetrators in these stories were men and women, old and young, married and single, heterosexual and homosexual: within the limited scope of this Project, we discerned no one type of perpetrator. We were, however, struck by the lack of organisational and professional support and counselling offered to staff who pursued justice either for alleged victims or for alleged perpetrators. For many interviewees, the horror of those situations is still with them, many years after the event.

As well as interpersonal forms of abuse, interviewees spoke of various forms of 'systemic abuse'. There were comments that "the way we set up services sets up the potential for abuse", echoed in Conway's (1996) Summary of Conclusions: "Abuse is inextricably linked to the way in which services operate" (xxi). As an example, some people cited the funding formulas for living arrangements which force service providers to make "immoral decisions" about who lives with whom - "it's not community care - it's a hell hole" - and then, if the service provider refuses an inappropriate funding package, government officers say that obviously the service 'can't cope'. Others spoke of unsupportive government officers who are confused about what to do and

who get caught between different funding guidelines, and of government officers making promises and renegeing on those promises to people with disabilities - "what you say is what you do".

At the Project workshop we asked participants to name some of the warning signs of potential abuse. As well as signs of physical injury and emotional distress, they noted the following: secrets; poor records; workers who generalise, trivialise or normalise abusive work practices; people with learning difficulties (especially nonverbal people) who cringe before workers; finding inappropriate or unusual items in a person's home; inappropriate behaviours and interactions between workers and constituents; staff confusions about the line between duty of care and restraint or control; lack of staff supervision; unwillingness to access external supervision; workers with 'weak boundaries' who are enmeshed in the lives of people with learning difficulties ("I'm their friend / parent" language). Interviewees stressed the very real dangers of workers seeing themselves as 'friends', and of families seeing workers as friends. There was agreement that it is important at all times for workers to follow up a gut feeling that 'all is not well'.

## **2. ORGANISATIONAL AND WORKER RESPONSES TO ALLEGATIONS OF ABUSE**

Most workers and their organisations strive to prevent abuse within their services. They employ a range of preventative measures such as careful staff selection, induction and training, ongoing monitoring and supervision of work practices, explicit policies and procedures (including reporting and grievance procedures), training and empowerment of constituents, community education and, most importantly, a demonstrated commitment to an organisational ethos of respect for constituents and prompt action on all allegations. However, despite workers' best efforts to prevent crime, abuse and exploitation, it does happen.

Abuse of people with learning difficulties, proven or alleged, sends shock waves through an organisation. It is, arguably, the most fundamental breach of trust and human service ethics, and it can rock an organisation to its foundations. The heat generated by alleged abuse can also set off brush fires within and without, and the smoke from those fires can obscure the victim from view - the victim may get 'lost' in the flurry of allegations and counter-allegations, and justice for all parties may be seriously compromised.

Senior staff need, therefore, to tread a careful path through the complexities, attending immediately to the safety and well-being of the alleged victim and victim's family, being mindful of natural justice for the alleged perpetrator and associated industrial issues, as well as keeping clear lines of communication with a staff team who may become increasingly preoccupied with the almost inevitable flow of whispers, rumours and (mis)information. Allegations of abuse create a highly charged environment: people who are later proven to be victims can receive poor treatment and little justice from an

organisation, and alleged perpetrators who are later proven innocent can lose service, or lose their jobs, and sometimes their careers.

Reportedly, there is a lot of confusion about: what is abuse? what are workers' rights? who do we complain to? what mechanisms do we use? what is 'normal practice'? what is a 'normalising' environment, and does it, for example, permit swearing and chaffing?

What is 'reasonable' restraint, for example, when a person is fitting, or aggressive towards their peers or to staff? Brown et al (1994) found in a study of staff knowledge of policy guidelines on sexual abuse that between 43% and 46% had read the policy but of these, 70% could remember nothing of what they had read.

Deinstitutionalisation to community care has changed the external conditions but not always people's understanding, attitudes and practices. Organisations need to be aware that it is their responsibility to train staff in these matters so that confusions do not lead to within service abuse.

When abuse is alleged in an organisation, staff may not report because of fear of defamation or retribution (to themselves or to the victim). They may also find themselves in conflict of interest situations being asked to support the family or the constituent to take the matter to the police or to lawyers, at the same time as there may be moves to sue their organisation for breach of duty of care, or for more serious matters. Workers can get caught between the alleged victim and their family, the alleged perpetrator, senior staff and investigating police. In such cases, workers become fearful of doing or saying anything, especially working with the alleged victim, and especially if they believe that the allegation may be false.

Families may not report because they may employ the alleged perpetrator, have a long history with the service, see staff as friends, and fear loss of service - they therefore tend to blame the organisation for lack of staff training, and want prevention for the future, rather than action on present or past incidents. It is a huge drain on most families to raise concerns and follow through on reporting processes. Some families, however, go the other extreme and, because of organisational, police, or legal delays, threaten to take justice into their own hands.

What, then, are effective and ineffective responses to allegations of crime, abuse and exploitation within services for people with learning difficulties?

#### **(a) Effective Responses to Allegations of Abuse**

Organisations which deal effectively with allegations of abuse acknowledge all allegations and implement public processes to address allegations, that is, they do not attempt to cover up what has allegedly occurred. They treat all allegations as serious and, when they are reasonably sure that there is substance to an allegation, they address the allegation promptly. .

Workers and their organisations need to act quickly, because "time destroys witnesses, and stress destroys memories". They ensure that the complainant has independent advocacy and support, and they suspend on pay the worker against

whom the allegation has been made, investigate and make a "reasonable determination" about the validity of a complaint as soon as possible.

In cases of alleged or reported criminal abuse between constituents, the organisation through its workers pursues natural justice for the victim, including assisting the complainant (and their family, if appropriate) to report the matter to the police or take the matter to the small claims tribunal. In cases of non-criminal abuse, they minimise contact between constituents, put on extra staff (eg, in residential) and require the perpetrator to stop the abuse and, if possible, make recompense to the victim. They may also refer either the victim or the perpetrator (or both) for counselling and, in extreme situations, may refuse service to the perpetrator. On the alleged victim's request, they may also facilitate a meeting between victim and perpetrator, for example, where the alleged victim is firm that they only want an apology.

In organisations who deal effectively with allegations of abuse, all administrative and direct work practices are based on what is best for constituents. Workers support constituents to be able to name abuse and to develop attitudes and practise behaviours that will help prevent abuse. They provide training to ensure that understanding of abuse and responses to complaints are consistent across staff, management, and families. Staff, families and constituents know the person(s) to whom they can make (minor and major) complaints, know the processes that will be followed, and know that the organisation has a commitment to address complaints. Importantly, organisations also attend to healing in the aftermath, providing immediate debriefing after a critical incident, and support to the victim and to staff who have been involved.

### **(b Ineffective Responses to Allegations of Abuse**

Chenoweth (1993 ) believes that the three key elements that pre-dispose an organisation to within service abuse are silence, invisibility and concealment.

Organisations that deal ineffectively with allegations of abuse tend to move to hush up and cover up the allegations. This is unjust and unethical, but also foolish: if the allegations become public knowledge, there is double trouble for the organisation (suspected abuse and concealment of suspected abuse), and if senior staff manage to hide the allegations, they give permission for more abuse to occur. As one interviewee said, "We have always found substance in allegations and, often, they reveal other incidents."

Some organisations believe that 'client confidentiality' [personal details/files etc.] is reason to stifle an allegation or complaint within an organisation. Some are tempted to treat the abuse as purely a medical matter, to 'sanitise' the abuse ("it was just ..."), to excuse 'minor' incidents ("we can handle it internally"), to transfer staff and hope "it will blow over", to treat the reported abuse as a matter of organisational risk management (to avoid bad publicity for organisation) rather than as a justice issue, and to try at all

costs to "keep everyone happy". However, as Schoener (1986) puts it, "There is no 'middle ground'. One is either part of the problem or part of the solution. To fail to take action is the ultimate 'crime of silence'" (4).

Organisations who are unaware of their responsibilities and want to cover up what has occurred tend to blame and punish the victim, for example, by over medicating, by putting the person on an inappropriate behaviour management program, or just by disbelieving the alleged victim's story. (It is said that even organisations who deal well with these matters tend to move the victim before the perpetrator, and alternate between advocacy and therapy for the victim.) They may also blame and scapegoat staff, and suspend the alleged perpetrator without proper process. Alternatively, committees and boards may avoid suspending the alleged perpetrator because they are fearful of wrongful dismissal. Such organisations fail to train staff in duty of care, and may even fail to respond appropriately to constituents' concerns that abuse is likely to occur (in one case, telling a young woman who feared rape in her workplace to "scream and run").

If they do pursue an internal investigation, they may not provide the full range of options and information to the victim or to their family, or contact the family at the earliest opportunity. They may be unaware of the potential conflict of interest in supporting the victim, or the victim's family, the alleged perpetrator, and the organisation's good reputation. They may refuse to involve police in what is a criminal matter, and require untrained workers to gather evidence for an internal investigation, potentially corrupting the evidence for the police or other authorities (Stewart Inquiry, 1995, xiii). They tend to involve too many workers in an internal investigation, with unclear roles and responsibilities. Typically, they also fail to provide support, supervision, or debriefing to traumatised staff. While it is sometimes difficult to find appropriate counsellors, especially for victims of male sexual assault, too few organisations try to refer for sex abuse counselling, debriefing and supervision.

It is little wonder, then, that staff in such organisations may be tempted to take allegations outside the organisation before reporting within. In big organisations, people can become 'objects', in small organisations staff know each other very well: in both cases, workers may feel that the organisation will punish them for a disclosure of alleged abuse, particularly if the organisation is under pressure to make things work, and struggling to survive with inadequate resources and with poorly trained staff. While it takes perseverance, time and considerable organisational resources (\$5000 minimum, it is said) to conduct a proper internal investigation, an organisation must be prepared to do this, not only because it is legally and ethically necessary but also because the long term reputation of the service may depend on it.

### **3. LEGAL, INDUSTRIAL and WORKPLACE HEALTH AND SAFETY ISSUES**

While most allegations have some foundation in truth, vexatious complaints do occur. In one organisation, for example, one constituent alleged sexual abuse by another constituent as a way of 'getting back' at her boyfriend. In another organisation, a young

man alleged financial abuse by a worker at the instigation of his family who disliked the worker after she had challenged them about their son's right to make his own decisions about how he spent his money.

### **Legal and Industrial Issues**

The Australian Services Union advises its members as follows:

(a) where the employee is called to a meeting with the manager, told of an allegation, and suspended, the employee should:

- ask for the reason(s) for the suspension;
- if no reason(s) is given, leave the workplace (for their own protection - they may say things they later regret);
- make a written request for the details of the allegation(s);
- if the request is refused, write to the next level of management with the request;
- if refused again, ask the Union to act on their behalf;
- seek Union and/or legal advice.

(N.B. If the matter goes to the Industrial Commission, the Commission can require management to give reasons for suspension of employment.)

(b) where the employee is called to a meeting, told the allegations and suspended, the employee should:

- not answer questions at this meeting;
- ask for the specifics of the allegation, and request another meeting, with a representative present (for example, a co-worker, or an advocate);
- meet with the manager with the representative;
- seek Union and/or legal advice.

(N.B. It is better if employees do what they can themselves in the first instance, before requesting Union involvement. If the allegations are not proved, it may then be possible for the employee to resume work in the organisation without having fractured their employment relationships too badly.)

(c) the Union can assess the employee's chances of success/retrieval of employment, and explore options with the employee:

- options may include that the employee keeps working, leaves employment, or requests a transfer.

(N.B. The Industrial Commission can order a transfer.)

(d) where allegations cannot be substantiated, the Union can help the employee negotiate a settlement with the organisation, either by an exchange of letters or by a deed of settlement. The options for settlement include:

- worker resigns, with or without compensation;
- worker returns to work (perhaps with transfer);
- organisation and worker agree not to defame the other.

(N.B. Most settlements include "shut up" provisions. It is rarely possible for workers to prove defamation - it is too costly and too long a process. Most disputes are settled outside the Industrial Commission and, except in cases of criminal allegations, police are unwilling to become involved.)

(e) worker and co-workers may take collective action:

- co-workers can write statements of support for the employee;
- co-workers may refuse to follow directives of a particular manager;
- co-workers may take their grievance to the next level in the organisation.

(N.B. Usually, issues are individualised, and co-workers are unwilling to support a worker against whom allegations have been made.)

(f) where police are called in:

- the Union will refer their member to the Union Legal Service (first visit is free);
- the Union will pursue natural justice for the employee from the organisation;
- if charges are laid, and if the organisation has used poor suspension or termination procedures, the Union will make representations to the employer so that, if the charges fall over, the employee can return to work on grounds of unfair dismissal.

*(N.B. It is essential, in all cases of alleged abuse, that workers keep accurate written records in work diaries and DOCUMENT EVERYTHING!!)*

### **Workplace Health and Safety Issues**

Workplace Health and Safety officers say that abuse is more likely to occur in organisations where there is a poor staff to constituent ratio, poor working conditions and, consequently, a resentful staff team. The Workplace Health and Safety legislation allows for a ban on unsafe workplaces.

All organisations should have workplace health and safety policies and train staff in relevant procedures. Some organisations develop practice guidelines, available to all staff as InfoSheets on relevant topics ( such as, medication, communicable diseases, handling, restraint, etc). Workers need to be aware that, if they are not meeting workplace health and safety requirements, they are breaching duty of care.

The legislation states that it is the responsibility of the employer to train and supervise staff in safe work practices. Further, employers must be able to prove that staff are trained, which means that all training should be documented, signed by both the worker and the supervisor. It is useful to link training to industrial awards, and review individual staff training requirements every 3, 6, or 12 months (depending on the risk levels of the work), as well as in the course of regular performance appraisals. The degree and frequency of necessary training is, however, very difficult for small organisations to afford, and currently there is very little money for training in funding grants to community-based organisations. Some organisations find that they therefore have to levy the work team budget to raise an annual training budget.

#### **4. PREVENTION STRATEGIES:**

**"Everyone's got a view, but no one puts resources to it"**

In this Project, there has been a strong focus on prevention, and we have found a large degree of commonality in what writers in the area of abuse and practitioners interviewed for the Project say about prevention.

Ten significant prevention strategies have emerged: an explicit organisational ethos which prohibits abuse of any kind; demonstrated organisational commitment to policies and procedures to respond quickly and effectively to allegations of abuse; appropriate training and support for constituents; careful recruitment and selection of staff; proper staff induction and probation processes; ongoing staff training, supervision and monitoring of work practices; adequate staff pay and safe working conditions; external monitoring and regulation; adequate funding and resourcing for community-based organisations; and community education and awareness campaigns.

Interviewees stressed that organisational culture, ethos and service values must state clearly that abuse is wrong and won't be tolerated, that the organisation, within a supportive team environment, encourages reporting of any allegations, and that staff must be aware of prohibited practices, service standards, safe practices, complaints procedures, as well as staff rights. Some organisations spell out their practice principles (see Appendix 1) and apply them explicitly in policies, and some define the various forms of 'abuse' and what they mean in work practice (see Appendix 3).

It is not, of course, enough to enshrine the rhetoric of abuse prevention in written practice principles without demonstrating an organisational policy commitment to act on allegations or suspicions of abusive practices. Interviewees believe that some organisations have been slow to set up complaints, grievance and reporting policies and procedures, and then slow to ensure that safeguards are in place, to monitor how they are working and to reinforce staff commitment to them. Apart from complaints, grievance and reporting policies, some organisations have explicit policies on, for example, abuse and exploitation, respect for people with learning difficulties (and for staff), and on unequal relationships (to clarify the issue of 'consent').

It is important, in framing policies and procedures, to ensure that staff can use ethical decision making frameworks to decide what are abuse issues and when and how they must act. Policies should not close the organisation to external scrutiny (for example, to the possibility of consultation with unions, police, and other agencies), and should encourage workers to maintain strong network contacts outside the organisation. Organisational commitment to follow through on allegations can be shown in quite simple ways, for example, by encouraging staff to 'think ahead' to anticipate and develop safeguards, and by regularly reviewing what the organisation does, and how well they do it, especially when incidents, however minor, occur.

Training and support for constituents and families to be able to name what is abuse, and name that it is wrong and a violation of their rights, to know how to report abuse and how to make a complaint within and without the service skills people to avoid or deal quickly with potentially abusive situations. (Organisations who work with itinerant people with learning difficulties may need to teach survival strategies so that they are able to recognise and avoid potentially abusive or dangerous situations.) Lumley et al (1997) believe that constituents must be able to "(a) recognise a potentially dangerous situation, (b) respond to the abuse situation by verbally refusing and/or escaping the situation, and (c) report the abuse situation" (462).

Brown and Mirenda (1997) suggest that workers teach and reinforce self-protection skills, such as "Your body is your own/Your feelings belong to you, Good, inappropriate, and confusing touches, Model privacy and boundaries, Talk about different kinds of relationships, Provide choices and teach people to say 'No', and Assist sexuality education" (24-30). A safeguard for all people with learning difficulties, emphasised by many interviewees, is a network of relationships that extends beyond carers (paid and unpaid), workers and families - a range of people to whom they can safely disclose fears and concerns.

Careful recruitment and selection of staff is crucial. It is known that some perpetrators have moved from agency to agency, and from state to state. Appendix 2 is an example of an application form that organisations can use to help screen these people out of the selection process

Organisations know that they can go a long way towards preventing abuse by attracting and paying for the most highly qualified staff possible. Because of budget constraints, this is not always something organisations can afford. It is essential, therefore, to check references carefully, look at gaps in work history, and be alert to workers who have moved frequently from service to service. It is not enough to rely on police checks, because police checks only elicit recorded convictions, not allegations that were unproven or not pursued. It may be possible to access the National Police Information Exchange which lists people who have been "adversely reported". However, the Exchange will only provide a 'yes' or 'no', that is, they can give no details of any adverse reports on the person in the past.

It is important, too, to involve families and constituents in the selection and interview processes. Applicants often 'give away' negative or patronising attitudes in interactions with constituents, and constituents usually pick up fast on someone who is not comfortable with them or who has weak professional boundaries. Questions to ask at interview can include whether the applicant has ever been accused of or charged with boundary violation and what their motivation is to do the work, as well as a range of questions (including scenario questions) to elicit values and attitudes. One organisation, at considerable cost, puts potential applicants through a training program before their application for a position is even considered. As Conway (1996, xxiii) notes, " Professionally qualified direct care staff are one of the most valuable resources in preventing abuse occurring ... While [this] may require additional funding, untrained direct care staff pose a significant risk to clients".

A number of interviewees stressed that organisations should resist the trend to employ technical, so-called 'content free' managers, with no people skills and no direct practice experience of working with people with learning difficulties. They commented that this was, in itself, an abusive practice. Chenoweth (1993, 40), quoting Cocks, suggests that "the dominant paradigm of human services to people with disabilities centre on bureaucratic, professional and technological models which encourage a utilitarian view of those who are personally vulnerable. In this way, people will continue to be at risk despite the measures employed to protect them".

Many abusive practices that stem from ignorance (such as, a belief that abuse between constituents is to be expected and is never criminal) can be nipped in the bud during staff induction and probation. Ideally, all new staff should receive a minimum of two days orientation and induction, so that their practice can be observed and they can be given feedback on their interactions with constituents. Many organisations now put new workers on three months probation, with periodic performance review and planning, professional development opportunities and on the job training. Interviewees stressed, however, that organisations need to monitor work practices constantly, during and after the probation period.

Staff training, supervision, and professional development is another key prevention strategy. As noted above, employers have a legal responsibility to provide appropriate training to staff, and workers can, in their defence against a complaint or allegation, use the fact that they were poorly trained by their organisation. Training usually includes workplace health and safety requirements, duty of care, conflict resolution strategies and strategies to deal with negative/abusive behaviours, and encourages workers to reflect on possible 'triggers' from their own backgrounds. It is essential to model and train staff in good communication skills, and not assume that the ways people relate to their friends and family will necessarily be suitable in the workplace. Williams (1995) writes: "If there is a single strategy that would reduce the amount of low-level victimization in the lives of people with learning disabilities, it is proper staff training about what constitutes an unlawful act". Staff training needs to be frequent, offered internally as well as externally.

Similarly, staff need access both to external professional supervision and line management supervision. External professional supervision allows workers to discuss sensitive and difficult situations, and sometimes to gain support to report doubtful work practices. Internal line management ensures that managers know their staff, and can monitor worker stress - it should always be OK for staff to ask for a break and to take it. It is good preventative practice to debrief staff immediately after a period of stressful work, and to offer the possibility of cross agency debriefing, if that is helpful. Line management can monitor that work practices are consistent across a staff team, and regular performance appraisals alert managers to staff training needs. Some organisations find (confidential) case conferences (including cross-agency case conferences) useful.

As already mentioned, staff pay and conditions can be contributing causes to abusive work practices. As one person asked, "How much can we expect from a poverty wage?" The potential for abuse is reduced when staff have adequate pay, safe working conditions, and the ability to develop their knowledge and skills within the organisation. Organisations which take an antagonistic attitude to staff membership of Unions tend, it is said, to entrench inward-looking, complacent and defensive attitudes about work practices.

There were, in fact, numerous comments about the need for external monitoring and regulation. Because organisations cannot monitor themselves, there need to be independent advocates for victims and independent monitoring and review of organisational practices. Conway (1996), in the conclusions to his Report, notes, "Independent monitoring must hold management of each service accountable for all incidents of abuse, including systemic procedures that result in abuse" (xxii) and "Clients must have access to impartial organisations or individuals who can monitor what happens to clients after abuse is disclosed or alleged" (xxiii). An example cited by one interviewee is the arrangements and protocols amongst a grouping of services in Minneapolis, USA, whereby workers are available (unpaid) to investigate complaints within services other than their own.

Another suggestion was for an independent body of external skilled consultants to investigate allegations, complaints, and rumours, and to monitor quality assurance, perhaps set up in a similar way to the Children's Commission. Other proposals were for a disability ombudsman, community visiting, legislated minimum standards in boarding houses, and a central register of carers (including transport staff). However, while interviewees believe that there should be real consequences for anyone who abuses a person with learning difficulties and that external monitoring should therefore be backed by the authority and resources to intervene if required, there is concern that an overemphasis on legislated solutions might drive poor practices underground: there needs therefore to be an at least complementary emphasis on processes to enhance service quality and abuse prevention.

Similarly, there were many comments about currently inadequate funding and resourcing of community-based organisations - "the government is giving

organisations responsibilities without the necessary resources". Organisations need increased resources to put in place better staff/constituent ratios, to conduct regular organisational reviews, and especially to train staff, management and volunteers. Some interviewees said that it is important to "match what you do with what funding you receive and tell government you can't do more". There was even a suggestion, half in jest, at the Project Workshop that disability organisations instigate a class action to obtain adequate funding for their work with vulnerable people. The Stewart Inquiry (1995) noted, "Many factors relevant to the occurrence of official misconduct at the [Basil Stafford] Centre are related to funding issues".

Finally, there is an urgent need for community education and awareness campaigns to alert the public to the potential abuse people with learning difficulties are constantly exposed to and reinforce that it is a citizen's responsibility to report suspected abuse. There was comment that campaign and education strategies, similar to those in the domestic violence prevention sector, could get the message out into the community that abuse is not to be tolerated and must be promptly reported. One interviewee thought that church leaders could assist by taking a public stand against violence and abuse within services.

The Queensland government's "Five Year Strategic Plan for Disability Services Queensland" (2000) has set seven strategic directions: "Strengthening Individuals, Families and Communities; Improving Access to Services; Developing and Reforming Services; Improving Quality of Services; Increasing Service Provision; Working Collaboratively; Increasing Safeguards and Advocacy" (5-6). The anticipated outcomes for the latter are "the rights of people with a disability are upheld, increased access to effective independent advocacy, and increased access to effective safeguards" (6). Similarly, the Victorian government has identified nine standards for disability services, including "freedom from abuse and neglect" (iii).

Adequate funding for disability services is not the only solution to within service abuse. As documented in this Project Report, interviewees and writers in the area have identified a range of necessary prevention strategies, of which adequate resourcing is only one. However, the crucial factor in realising the hoped-for outcomes of the Queensland government's seven strategic directions, especially Safeguards and Advocacy, will be the political and bureaucratic commitment to adequately and flexibly resource disability services so that they can attract well-qualified staff and provide ongoing training. This would go a long way towards addressing not only the concerns and suggestions recorded in this Project, but also the consistent advice and recommendations of inquiry heads, writers and practitioners who seek to prevent abuse of people with learning difficulties within services.

# **APPENDICES**

**APPENDIX 1: Example of Organisational Practice Principles**

**APPENDIX 2: Example of Staff Application Form**

**APPENDIX 3: Example of Policy on Allegations of Abuse Towards Consumers**

**APPENDIX 4: Administrative Safeguards: A Checklist**

**APPENDIX 5: Useful Resources**

# APPENDIX 1: Example of Organisational Practice Principles

## [Organisation] Practice Principles

1. We enable people to exercise their rights.
2. We extend unconditional positive regard.
3. We enable people to make their own decisions.
4. We enable people to do things for themselves.
5. We enable people to utilise wider community resources.
6. We work in ways to maximise the connectedness of [organisation] and service users in the community.
7. We see the person holistically (eg as part of their families, and social, economic and political context).
8. We believe that families are important.
9. We are workers, not friends.
10. We maintain confidentiality.
11. We share information amongst workers.
12. We challenge self- and other-harming behaviours.

*These practice principles spell out the service ethos of a community-based disability organisation, and are stated clearly in the organisation's Manual. The Manual, prefaced with the history and purpose of the organisation and the programs offered, gives a full set of organisational policies and procedures, the organisational structure, and the role descriptions of Committee and Staff. The Policies include, amongst others: Complaints and Disputes; Valued Status; Privacy, Dignity and Confidentiality; Exploitation; and Sexual Harassment.*

## APPENDIX 2: Example of Staff Application Form

### **Counsellor/supervisor/volunteer Application Form** *[used by an organisation working with survivors of abuse]*

Date

Name

Address

Phone (work)

(home)

#### **Current Employment**

Name of Agency/Company

Position/Title

#### **1. Degrees Held or Expected**

#### **2. Are you Licensed or Certified by a Professional Body?**

Areas of Competency or Professional Practice for which Licensed/Certified

#### **3. Has Disciplinary Action of any sort ever been taken against you by a Licensing Board, Professional Association, Educational, Training or Religious Institution?**

#### **4. Are there any Complaints pending against you before any of the above-named bodies?**

#### **5. Have you ever had a Civil Action brought against you relative to your professional work or is any such action pending?**

***NOTE: If you have answered YES to any of the above three questions, please attach an explanation.***

#### **6. Training and Clinically Relevant Experience**

Practicum Placements and other supervised clinical experience

Agency (Client populations and treatment modalities)

#### **7. Relevant Work Experience**

##### **A. Current and Past Employment in Counselling/Human Service Settings**

Name of Agency and Description (Job Titles, Settings, Duties, Dates)

##### **B. Have you ever been asked to resign or been terminated by a training program or employer?**

- C. Experience as Clinical Supervisor  
Description (Settings, Type of People Supervised, Client Populations, Treatment Modalities, Approximate Hours)

**8. General Information**

- A. Relevant Present and Past Volunteer Work
- B. Areas of Special Expertise (eg, sexual abuse counselling, chemical dependency, sign language, language other than English)

**9. Expectations Regarding the Counselling and Support Service**

Why do you want to be on the counselling register at {organisation}?

How did you learn of/become acquainted with [organisation]?

What do you expect from this experience?

**10. References**

Give the names, agency/institution affiliations and phone numbers of 3 people who are familiar with or have supervised your clinical work within the last five years.

**STATEMENT OF APPLICANT (Please read this carefully before signing)**

All information submitted by me in this application is true to the best of my knowledge. I understand that any significant misstatement in, or omission from, this application may be cause of denial of appointment to, or cause for dismissal from, the counselling register of [organisation].

I authorise [organisation], its staff and representatives to consult with persons or institutions with which I have been associated and with others, including past and present employers, who may have information bearing on my professional competence, character and ethical qualifications. I release from liability all representatives of [organisation] for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also release from liability all individuals and organisations who provide information to [organisation] in good faith and without malice concerning my professional competence, ethics, character, and other qualifications.

I understand and agree that I will notify [organisation] of any change of circumstance in my job or training status, licensure, censure or sanction by professional bodies, or any other information relating to my ability to perform as a counsellor on the register of [organisation].

NAME  
SIGNATURE

DATE

## **APPENDIX 3: Example of Policy on Allegations of Abuse Towards Constituents**

### **Procedure for Responding to Allegations of Abuse (of any kind) of a Constituent by Any Person**

#### **Preamble:**

The procedures of [organisation] are subject to Commonwealth and State legislation, the policies and procedures of [sponsoring organisation], and obligations to duty of care.

All external aspects of this procedure are subject to the consent of the constituent (or constituent's delegated advocate) - the constituent should be fully informed of the possible consequences of decisions.

The constituent must be included in the decision making process as fully as possible.

The constituent must be fully informed of the procedures followed and action taken, throughout the process.

The constituent's right to privacy, dignity and confidentiality in all aspects of their life must be recognised and respected.

#### **Legislation, Standards or other related policies:**

Queensland Disability Services Act (1992)

Disability Discrimination Act (1992)

National Disability Standards

Policy on Sexual/Physical/Emotional/Financial Abuse of a Constituent

Sexual Harassment Policy

Duty of Care Policy

Household Management Procedures relating to Financial Records and Management of Constituent' Finances

Constituent Grievance Procedure

Staff Grievance Procedure

#### **Definitions:**

For definitions of abuse, sexual abuse, physical abuse, sexual harassment, emotional abuse and financial abuse, refer to Policy No. [X] on Sexual/Physical/Emotional/Financial or any kind of Abuse of a Constituent.

**Allegations:** Comments either verbal or in writing which indicate that the person making the comments is concerned that the behaviour of another person towards a constituent may constitute abuse. Comments may be made in the context of a formal conversation specifically about the issue, or may arise in an informal discussion. All allegations must be investigated.

## **Procedure:**

1. Any allegation of sexual/physical/emotional/financial abuse must be reported to the Co-ordinator or the Manager **immediately, day or night**.
2. The constituent should be informed of all the dispute mechanisms available to them including external organisations, such as the police, legal centres, and advocacy services.
  - 2.1 The constituent should be encouraged to involve a support person or advocate in the process.
3. The Co-ordinator or Manager should confirm the allegation by speaking firstly to the constituent and secondly to their support workers.
4. The incident must be verbally reported to the Manager within 24 hours of the occurrence.
5. If the alleged incident involves a serious criminal offence, the Police should be contacted immediately.
6. The Co-ordinator or Manager should determine whether a medical examination is needed and organise the medical examination if required.
7. If the alleged incident involves a staff member, the staff member against whom the allegations are being made must be removed from contact with the constituent(s) immediately, pending a full investigation (suspension on full pay). Refer to Procedure for Conducting an Investigation.
8. All staff involved must complete written reports documenting the incident and forward the reports to the Manager within 24 hours. All documentation and reports must be available to constituents, who should be fully informed about the content of the report.
9. The Co-ordinator and the Manager should interview the person making the allegations of abuse as soon as practicable. Refer to Procedure for Conducting an Investigation.
10. The Co-ordinator, or the Manager and Co-ordinator, should interview any other relevant people as soon as practical. Refer to Procedure for Conducting an Investigation.
11. Relevant external agencies should be involved as required and appropriate. The Co-ordinator, or the Manager and Co-ordinator, should determine which external agencies to involve and in what capacity.
  - 11.1 External agencies should be involved if:
    - \* the incident involves a serious criminal offence
    - \* the constituent or constituent's advocate requires involvement of external agency or agencies
    - \* the Co-ordinator or Manager and Co-ordinator determine that this would be the usual course of events taken by other members of the community in a similar incident.
  - 11.2 If an incident involves a constituent under the age of 18 in the care of the Department, the Department of Families, Youth and Community Care should be notified.
12. In the event that a constituent is dissatisfied with the process followed, they should be informed of other action they can take, and informed of the possible outcomes or consequences of the action and, if appropriate, should be supported to take further action.

**Approved:**

**Date:**

**Review Date:**

## APPENDIX 4: Administrative Safeguards: A Checklist

The following Checklist is adapted from Gary Schoener's (1989) Checklist to "limit the risk of sexual exploitation by psychotherapists". Schoener is director of a counselling centre for victims of therapist abuse in Minneapolis, USA. The Checklist, with adaptations, is useful for all human service organisations that wish to prevent abuse. We would also like to acknowledge the Esther Trust for providing the international link to Schoener's work.

### **Staff Selection & Hiring**

- Does your job application explicitly ask about:
  - past terminations of employment/resignations?
  - past ethics complaints?
  - past professional/licencing/registration board complaints?
  - past lawsuits, whether adjudicated or not?
  
- When hiring professionally trained staff, do you directly contact professional boards/associations concerning areas of competency, status of registration, and the existence (or lack of) complaints?
  - in this state?
  - in other states?
  
- Do you check by direct conversation (not just letter of reference) with past supervisors about the applicant's
  - likely strengths and weaknesses working in your agency setting?
  - willingness to be supervised and work as a member of a team?
  - history of complaints, or problems, with other staff?
  - history of client complaints? and
  - any concerns they might have about the person's ability to perform in your agency (any needs for special care or supervision?)

## **Staff Policies**

- Do you have a written policy forbidding:
  - physical/emotional/financial abuse of constituents?
  - sexual contact with constituents and with ex-constituents?
  - romantic involvement with constituents?
- Does your policy also provide for support staff, volunteers etc.?
- Do you have a sexual harassment policy?
- Do you have a written policy for handling complaints of unprofessional conduct, such as allegations of abuse against constituents?
- Do you have a plan or mechanism for the investigation of complaints by constituents or others?
  - Do you have outside consultants who can assist in such investigations?
  - Do you have an Ethics Committee or Professional Standards Review Committee that reviews complaints?
  - Do you have a method of reporting and investigating complaints against the Director of your service?

## **Complaint Resolution**

Are all complaints processed as complaints and taken seriously?

Are complainants given reassurance and thanked for coming forward (regardless of your initial assumptions about the validity of the complaint)?

Are constituents given support and offered help to find appropriate independent resources/advocacy?

Do you have procedures for deciding whether to temporarily suspend a staff member pending the outcome of a review of a complaint?

Are all staff who are involved in the investigation of complaints clear about the limits of privacy and their reporting duties?

Is some resolution reached on all complaints, or do you allow some of them to remain moot if a staff member voluntarily resigns?

After you have decided on action relative to a complaint, are the complainants always given feedback as to the final disposition?

When you receive a request for a recommendation that asks about any history of misconduct, do you pass on relevant information?

## **Staff Education**

Are all staff given written copies of policies?

Is there a new employee orientation at which these are explained and key policies emphasised?

Are there training sessions on the issues of boundaries at least once a year?

Following an incident of serious misconduct, is there a special session held to discuss what can be learned from the incident?

## **Staff Supervision/Peer Review**

Do you have regular supervision and consultation with staff?

Do you have a professional standards review system?

Is there an automatic review of:

work with constituents which exceeds usual duration?

situations in which excessive dependency is evident?

situations in which seductive behaviour is observed by other staff?

Is long term work periodically reviewed as to:

work goals and progress towards them?

plans for termination?

Does your service have an atmosphere that encourages constructive questioning among staff?

Are there clear, non-threatening pathways for making observations/concerns known to management by

direct work staff?

support staff?

When staff have obvious personal problems or are in distress:

do other staff generally give them feedback?

is there a clear mechanism, which is used, to bring about feedback and encourage them to seek help?

are work duties reviewed in light of obvious personal problems/distress?

are there readily available interventions when relationships with constituents become sexualised/romanticised/potentially abusive?

use of a co-worker to sit in on sessions?

referral to another worker, program or service?

## **Constituents**

Do you provide new constituents with information which:

actively asks for feedback on the service?

identifies an easy-to-use complaint mechanism?

provides guidelines to evaluate the service?

Is it general staff practice to carefully assess a constituent's view of past service at your agency or elsewhere?

Do you routinely survey constituents' satisfaction with the service?

## APPENDIX 5: Useful Resources

Australian Association of Social Workers (1999) AASW Code of Ethics: 2nd Draft for Consultation, National Ethics Committee, Canberra.

Advocacy Network for Male Survivors of Sexual Assault (1996) "Sexual Assault in Queensland's Male Prisons", Survey Report, Brisbane.

Aiello, Denise et al (1986) "Strategies and Techniques for Serving the Disabled Assault Victim: A Pilot Training Program for Providers and Consumers", Sexuality and Disability Vol. 6 No. 3/4.

Allington, C. (1992) "Sexual Abuse within Services for People with Learning Difficulties" in Mental Handicap Vol. 20 (2): 59-63.

Berkman, Anne (1986) "Professional Responsibility: Confronting Sexual Abuse of People with Disabilities", Sexuality and Disability, Vol. 7, No.s 3 &4.

Brown, H. et al (1994) "'Alarming but very necessary': Working with staff groups around the sexual abuse of adults with learning disabilities", Journal of Intellectual Disability Research, 38, 393-412.

Brown, Jacqueline and Miranda, Pat (1997) Making a Difference. Preventing and Responding to Abuse of People with Developmental Disabilities: A Learning Guide, Ministry for Children and Families, British Columbia, Canada.

Bure, Lilac et al (1998) "Dealing with Sexual Abuse of Adults with a Developmental Disability Who Also Have Impaired Communication: Supportive Procedures for Detection, Disclosure and Follow-up", Canadian Journal of Human Sexuality, Vol. 7 (1).

Chenoweth, Lesley (1993) "The Mask Of Benevolence: Cultures of Violence and People with Disabilities", Cultures of Crime and Violence: The Australian Experience, ed. Judith Beset et al, Journal of Australian Studies, No. 43, Special Edition.

Cole, Sandra (1986) "Facing the Challenges of Sexual Abuse in Persons with Disabilities", Sexuality and Disability Vol. 7 Nos 3 & 4.

Connate, Jon R. et al (1989) "What Sexual Offenders Tell Us about Prevention Strategies", Child Abuse and Neglect, Vol. 13, 293-301.

Conway, Robert et al (1996) Abuse and Adults with Intellectual Disability Living in Residential Services. A Report to Office of Disability, National Council on Intellectual Disability and Australian Society for the Study of Intellectual Disability.

Department of Families, Youth and Community Care (1999) A Discussion Paper on Preventing and Responding to the Abuse, Assault and Neglect of People with a Disability, Queensland Government.

Department of the Prime Minister and Cabinet, Office of the Status of Women, and National Committee on Violence against Women (1993) Access to Services for Women with Disabilities Who are Subjected to Violence, Australian Government Publishing Service.

Department of Health and Community Services (1994) It Happened to Us: Men Talk about Child Sexual Abuse, Prevention and Education Unit, Victoria.

Disability Service Queensland (2000) Five Year Strategic Plan for Disability Services Queensland (Draft), Queensland Government.

Fifield, Bennet B. (1986) "Ethical Issues Related to Sexual Abuse of Disabled Persons", Sexuality and Disability, Vol. 7, Nos 3&4.

Fallowell, Deborah (1993) "Supporting Empowerment: Development of the Participation of People with a Disability in the Quality Assurance of the Services They Receive", Quality and Equality in Intellectual Disability: Proceedings of the ASSID National Conference, November 30 - December 5, 1993, NSW.

Frawley, Patsie (1998) Working with Victims/Survivors of Sexual Assault with an Intellectual Disability: Practice Guidelines, Training Manual, Literature Review, Sexual Assault Project, Family Planning Victoria.

Furey, E. M. and Niesen, J. J. (1994) "Sexual Abuse of Adults with Mental Retardation by Other Consumers", Sexuality and Disability, 12 (4):285-306.

Furniss, Tilman (1997) The Multi-Professional Handbook of Child Sexual Abuse: Integrated Management, Therapy and Legal Intervention, Routledge.

Hingsburger, Dave (1996) "Counselling Strategies: Some Adaptations for Sex Offenders with Developmental Disabilities", Canadian Journal of Human Sexuality Vol. 5 (1).

Intellectual Disability Services (1997) "Procedures for Client Injuries, Suspected Abuse or Neglect", Department of Family Services and Aboriginal and Islander Affairs, Queensland.

Kielbauch-Cruz, Virginia, et al (1988) "Developmentally Disabled Women Who Were Molested as Children", Social Casework, September.

Lumley, Vicki A. and Miltenberger, Raymond G. (1997) "Sexual Abuse Prevention for Persons with Mental Retardation", American Journal on Mental Retardation, Vol. 101, No. 5, 459-472.

Law Reform Commission of New South Wales (1992) Issues Paper No.8, People with an Intellectual Disability and the Criminal Justice System, Sydney.

Law Reform Commission of New South Wales (1993) People with an Intellectual Disability and the Criminal Justice System: Consultations, Sydney.

Macdonald, Kathy, Lambie, Ian, and Simmonds, Les (1995) Counselling for Sexual Abuse: A Therapist's Guide to Working with Adults, Children and Families, Oxford University Press.

Marchetti, A. and McCartney, J. (1990) "Abuse of Persons with Mental Retardation: Characteristics of the Abused, the Abuser and the Informers", Mental Retardation Vol. 28 (6): 376-381.

McCarthy, Michelle (1993) "Sexual Experiences of Women with Learning Difficulties in Long-Stay Hospitals", Sexuality and Disability, Vol.11, No. 4.

McCarthy, M. and Thompson, D. (1996) "Sexual Abuse by Design: An Examination of the Issues in Learning Disability Services" in Disability and Society No. 11 (2): 205-217.

Morath, Phillip (1997) "Systemic Abuse and Neglect: A Model to Predict Its Occurrence & Evaluate Preventions", ASSID National Conference, Brisbane.

Muccigrosso, Lynne (1991) "Sexual Abuse Prevention Strategies and Programs for Persons with Developmental Disabilities" in Sexuality and Disability, Vol. 9, No. 3.

NSW Department of Health and Disability Council of NSW (1997) Equity: A Kit Developed for Sexual Assault Services of NSW, Robyn Kennedy and Co.

O'Brien, John (1990) "What Can We Count On To Make And Keep People Safe? Perspectives on creating effective safeguards for people with developmental disabilities", Responsive Systems Associates, Georgia.

Parker, Tracee and Abramson, Paul R. (1995) "The Law Hath Not Been Dead: Protecting Adults with Mental Retardation from Sexual Abuse and Violation of Their Sexual Freedom", Mental Retardation, Vol. 33, No. 4, 257-263.

Petersen, Marilyn R. (1992) At Personal Risk: Boundary Violations in Professional-Client Relationships, Norton.

Queensland Advocacy Incorporated (1996) "Abuse and Neglect by Service Providers", December Newsletter.

Queensland Corrective Services Commission (1998) "Prevention and Management of Sexual Assault in Correctional Centres", Policy and Procedures Manual (Custodial Corrections).

Stewart, D. G. (1995) Report of an Inquiry Conducted by the Honourable D G Stewart into Allegations of Official Misconduct at the Basil Stafford Centre.

Roeher Institute (1993) Answering the Call: The Police Response to Family and Care-giver Violence against People with Disabilities, North York.

Roeher Institute (1995) Harm's Way: The Many Faces of Violence and Abuse against People with Disabilities, North York.

Schoener, Gary (1989) Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention, Walk-In Counselling Service, Minneapolis.

Simons, K. (1990) Sticking Up For Yourself: Self-Advocacy of People with Learning Disabilities, Joseph Rowntree Foundation, York.

Sobsey, Dick (1994) Violence and Abuse in the Lives of People with Disabilities. The End of Silent Acceptance? Paul Brookes Publishing.

Tichon, Jennifer (1998) "Abuse of Adults with an Intellectual Disability by Family Caregivers: The Need for Family-Centred Intervention", Australian Social Work, Vol. 51, No. 1.

Victorian Human Services (1999) Victorian Standards for Disability Services, Victorian Government.

Wallis Consulting Group (1996) Proposed Plan of Action for the Prevention of Abuse and Neglect of Children with Disabilities, National Child Protection Council and Department of Health and Family Services, Commonwealth of Australia.

Williams, Christopher (1995) Invisible Victims. Crime and Abuse against People with Learning Difficulties, Jessica Kingsley.

Wolf, Steven and Smith, Tim (1989) "What Sexual Offenders Tell Us about Prevention Strategies", Child Abuse and Neglect, Vol. 13: 293-301.

Womendez, Chris and Schneiderman, Karen (1991) "Escaping from Abuse: Unique Issues for Women with Disabilities", Sexuality and Disability Vol. 9, No. 3.

WWILD - SVP Service (1999) Infosheets, Brisbane.

Youth Sector Training Council (1999) From Strength to Strength: A Resource Kit, Brisbane.

# PART B

## HEALING AND MOVING ON

POST TRAUMA SUPPORT  
FOR  
PEOPLE WITH INTELLECTUAL/LEARNING DISABILITIES  
WHO ARE VICTIMS OF CRIME

### *The Survivor Psalm*

*I have been victimised.*

*I was in a fight that was not a fair fight.*

*I did not ask for the fight. I lost.*

*There is no shame in losing such fights, only in winning.*

*I have reached the stage of survivor and am no longer a slave of victim status.*

*I look back with sadness rather than hate.*

*I look forward with hope rather than despair.*

*I may never forget, but I need not constantly remember.*

*I was a victim.*

*I am a survivor.*

(Frank M. Ochberg, 1993)

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## **1. EXPERIENCE OF TRAUMA: NORMAL REACTIONS TO EXTRAORDINARY EVENTS**

There is growing recognition and concern that people with learning difficulties not only suffer great distress as victims of crime, but may also have multiple experiences of victimisation (Sobsey, 1994, Sobsey et al, 1991). Because of this and because of the nature of their learning difficulties, many find it difficult to re-establish their lives after a trauma, to 'move on' from victim to survivor. Indeed, for some people, large and small traumas seem to become "part of their everyday existence": there is an "increased level of tolerance built up by people for whom victimisation is very frequent. They do not report each individual incident because some come to stand out as more serious than others and because to report each occurrence would involve them in constant contact with the authorities" (Williams, 1999, 29).

All victims of crime experience trauma, with consequent short, medium or long-term effects on their physical and emotional health and their quality of life. People with learning difficulties who are victims of crime are especially vulnerable to the traumas of victimisation and are at special risk of developing long term post trauma illnesses because they commonly have a history of prior traumatic experiences, including childhood rejection/abuse by peers and family members, school bullying, rape and assault, and exploitation in many forms.

However, for all the pain of abuse and victimisation, people with learning difficulties are as capable as other people of making the shift from victim to survivor, and of moving on in their lives. A crucial factor in recovery for all people who experience trauma is timely, effective and informed support. It is important, then, that disability workers and carers understand the nature and consequences of trauma, the ways trauma can affect people with learning difficulties, and the responses and strategies that can assist people recover.

While it is true that we all experience stresses and misfortunes of various kinds and in varying degrees, because stress is a largely unavoidable part of everyday life, it is also true that some of us cope better, or are better equipped to cope, than others, because all of us learn to cope with stresses in our own ways. Most of us don't welcome stress but, if we have been fortunate enough to have developed a healthy and resilient self-identity, we believe that we can cope. Underpinning that belief is the sense that the world is, by and large, a secure and predictable place, a place where we can act on and have some control over what happens to us.

Trauma is not a normal part of life. Traumas are abnormal, extraordinary and overwhelming events - unpredictable and uncontrollable events with radically threatening consequences for the person involved. A person under stress or a person suffering depression or anxiety may say that 'things are bad' or even 'very bad': a person who is traumatised no longer has even that much perspective. Trauma knocks out the foundations of their world, their sense of security and predictability and their sense of a world that they can influence and control.

As Herman (1992, 33-35) describes it: "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning. Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close encounter with violence or death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe".

## **Common Reactions to Trauma**

When a trauma occurs, our bodies and minds move rapidly (some say, instinctively) into survival mode. We go on to high alert. Some reactions are well known - the surge of adrenalin through the body, cold clammy hands, shallow breathing, concentrated attention, racing heart, and so on. At the time, these reactions are unpleasant but helpful, because they prepare us for maximum effort, for fight or flight to survive the threat.

But survival reactions come at a cost. Herman (1992) again: "Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory ... [these changes tend] to persist in an altered and exaggerated state long after the danger is over ... Traumatic symptoms have a tendency to become disconnected from their source and to take on a life of their own."

Grossman (1999) explains: "[O]nce you get up to 115 [heart]beats per minute, about double your normal resting heartbeat, you find your motor skills begin to deteriorate ... once you get beyond 145, things begin to break down ... once you get up to about 175 beats per minute ... the forebrain shuts down [and] the mammalian brain takes over ... the mammalian brain [midbrain] has hijacked the forebrain ... cognitive processing begins to deteriorate, you lose your peripheral vision, tunnel vision occurs, you lose your depth perception, you lose your near vision ... [I]n a survival situation ... your mind will cut out all unnecessary data ...".

These altered neurological responses tend to become etched pathways in the brain. After the trauma experience, sometimes long after, apparently minor 'triggers' can precipitate the same brain responses as those of the original trauma, so that some people may re-experience the same survival mind and body responses many times over. As part of their recovery, some people have to learn to "delink the midbrain from the forebrain" and regain a sense of control (Grossman, 1999). Trauma counsellors do not consider these post trauma reactions to be pathological, but to be part and parcel of the aftermath of a trauma and of the recovery. Counsellors can, however, moderate the impact of post trauma reactions through debriefing, education and support.

Trauma sufferers, and people around them, may get impatient that they are not 'snapping out of it' and getting on with their lives. Support workers and counsellors may need to explain to the sufferer and their friends and families that what they are experiencing are 'normal' post trauma reactions.

In the first few weeks following a trauma, many people suffer physiological reactions, such as headaches, bowel/bladder problems, skin disorders, sleep disorders (e.g. nightmares, difficulty falling asleep etc.), digestion problems, painful menstruation. They may also experience emotional/behavioural reactions: feelings of inadequacy/helplessness, concentration difficulties, hypochondriasis, sadness, isolation, depression, mood swings, lapses in memory, emotional numbing, vivid and recurrent recollections, and atypical behaviour, for example, delinquent acts like stealing or vandalism. They may experience a loss of previous levels of responsible behaviours, changes in activity, a decrease in social interests and activities, and a decline in interest in the opposite sex.

After trauma, many people feel that they have lost control, and that they are floundering helplessly in a welter of physical and emotional experiences that they don't recognise as 'normal'. They may fear they're 'going nuts'.

Trauma sufferers and significant others in their lives need to appreciate that reactions to trauma are global, affecting all aspects of the survivor's life. The traumatised person's suffering is very real, and the intensity of their post trauma reactions may disturb people around them. The intensity of their reactions to trauma and their capacity to recover can be affected by the nature of the trauma itself (eg assault with burglary is an experience of a double loss), the degree to which the person has been able (or not) to take action and exert control during the trauma, the meaning of the traumatic event to the person, previous experiences of trauma, prior self-concept and self-esteem, and the support networks or lack of networks in the recovery environment.

Over time, most people recover from trauma. They may never forget what has occurred, never be 'quite the same person as before', but mind and body gradually heal, and post trauma reactions become fewer and less severe as people are able to integrate what has occurred and move on.

There are some people, however, who develop Posttraumatic Stress Disorder (PTSD). According to Meldrum and Raphael (1994), the factors that affect people developing PTSD are the nature and intensity of the stressor, the characteristics of the person (eg. general health, level of coping ability), their history of past stressful life experiences, and the supports (or lack of) available in the recovery environment.

## **People with Learning Difficulties and Reactions to Trauma**

We know that people with learning difficulties are vulnerable to the traumas of victimisation (and repeated victimisations), that they have commonly had prior experiences of a range of traumas, that they often suffer from poor self-esteem, that they commonly have restricted coping abilities, and that they often lack support networks of people who can rally round to assist. As well, people with learning difficulties may have pre-existing mental health problems, including depression (often under-diagnosed), or may develop mental health problems as a result of the trauma.

While it is important to separate out anxiety and depression from full-blown PTSD, and important not to assume that everyone who has experienced trauma will go on to develop PTSD, the factors predisposing people to PTSD (and the factors influencing recovery) tend to 'jump out' at workers, families and carers who are wanting to assist people with learning difficulties recover from trauma. People with learning difficulties would seem, on all counts, to be highly vulnerable to developing PTSD or, at the very least, to requiring a prolonged recovery period. It is well, therefore, that workers, families and carers are alert to the signs and symptoms of PTSD. The diagnostic criteria of PTSD are given in Appendix 1.

## **2. SUGGESTED POST TRAUMA PRACTICE RESPONSES AND STRATEGIES**

### **(a) A Response Framework**

When people with learning difficulties disclose that they have been a victim of a crime, it helps if workers and carers have in mind an overall response framework - that is, a way of reminding themselves and others that there are a range of necessary and possible responses. Within an overall framework, responses will vary according to the needs of the individual person and their circumstances. Workers may respond differently when a disclosure is about very recent or about past events - when the person is in immediate crisis or when the person has lived with the pain of a trauma for many years. Similarly, one person may need only short term crisis intervention, another long term and in-depth work. A worker's or carer's involvement in a person's recovery may be as brief as an appropriate referral and infrequent back-up support, or as extensive as ongoing counselling and daily contact.

It seems from discussions with practitioners that an implicit response framework that workers carry in their heads is: 'safety and support', 'rights and redress', and 'advice and referral'.

This framework can prompt workers to offer a comprehensive response to trauma, paying attention to: (i) the person's sense of physical and emotional safety and their need for support; (ii) their right to pursue justice and legal redress for what has

occurred; and (iii) the possible benefits of accessing specialist advice and referral (for example, medical or counselling assistance).

(i) Safety and Support

A person's sense of personal safety, both physical and psychological, is a priority. The trauma of victimisation is an assault on basic psychological well-being. People's sense of safety, trust, control, self-esteem and human connectedness have all been assaulted and are, after the trauma, radically weakened. Victims need people to hear and believe what has happened to them, to confirm that it was not their fault, and to reassure them that their reactions to the trauma are normal, that they are likely to pass, and that others can help them put the pieces together again.

For people to feel safe, they may need help with practical tasks, such as to move accommodation, to think through ways to avoid the alleged offender, to report missing effects, to call friends, family, significant others for support, etc. Above all, people need support to know that they are not alone with their distress and fears, and that others will help them establish a 'cocoon of safety' while they recover from their ordeal. Workers may need to consider risk management strategies for a person with a learning difficulty who may be suicidal. They may also need to ensure that the person has support to access information and to take measures that will help them feel safe.

(ii) Rights and Redress

Williams (1999, 51) describes the range of emotions that people may feel as a victim of a crime: "... victims of crime may feel fear, shame, resentment, anger against the offender and the criminal justice system, humiliation ... They may wish to be proactive, protecting themselves from further offences, or the experience may disempower them and make them feel - at least temporarily - less able to cope. In some cases they withdraw into themselves and retreat from painful reminders of what they have experienced or simply refuse to believe that it has happened".

In the midst of responding to a victim's painful emotions, it is important that workers and carers keep in mind that a crime has occurred (or is alleged to have occurred), and that a person with a learning difficulty has the same right as any other citizen to seek legal redress for the wrong that has been done to them. Seeking and gaining justice can be an important part of a person's healing and recovery from trauma.

While there are numerous factors which determine whether a crime will in fact be reported (such as organisational policies, constraints on housing etc.), the decision to report a crime should rest primarily with the person who has been victimised. If and when people with a learning difficulty decide *not* to report a crime, it should not be because they have not understood what they need to do, or because other people don't think they'd be believed or be seen as credible witnesses. It is certainly not easy for victims with learning difficulties to have their cases successfully prosecuted through the courts, but they do have the right to try and, whatever the outcome, to feel that they have done what they could to gain recognition as a victim of a crime and to have a wrong redressed.

People with learning difficulties who are victims of crime and their workers may need legal assistance. If a person wants to report the crime, they will need to go to the police, sometimes (on their request) with a worker's or carer's support. Later, and again perhaps with support, they may need to go to lawyers, court officials, and Victim Support Service. (The VOICES Workbook provides guidance on pursuing justice through police and legal processes.)

(iii) Advice and Referral

Either at the time of the trauma or very soon after, a victim of a crime may need medical assistance for injuries and/or for appropriate medication. They may need help from housing agencies, health organisations, legal advice centres etc. They may need assistance to pursue grievance procedures, or to speak to an independent third party. Further down the track, the person may want to join a group (say, a survivors' group), or attend classes in self-defence or sex education or self-esteem.

Workers and carers may themselves want to consult colleagues with special expertise, or seek debriefing or supervision for their work. Secondary or 'vicarious' victimisation, where workers and others have been exposed to victims' horrifying accounts of violence and terror, can take its toll, particularly if workers have themselves had prior trauma experiences that may be triggered. It is a sign of strength, not weakness or incompetence, for a worker to seek out support and supervision while engaged in post trauma support work.

**(b) Post Trauma Counselling and Support Strategies**

(i) Assessing the Impact of Trauma

Burke (1998) has suggested a five step procedure to assess the impact of trauma.

1. *Build rapport and trust.*
2. *Assess person's confusion and their psychological, physiological, and emotional reactions - help the person make sense of their confusion.*
3. *Ask about 'changes':*
  - When did the change(s) occur?*
  - What caused the change(s)?*
  - What is the difference now?*
  - What is happening now as a result?*
4. *Check:*
  - Has a past trauma occurred?*
  - Is the person re-experiencing symptoms/reactions?*
  - Does s/he have avoidance symptoms/reactions?*
  - Does s/he have arousal symptoms/reactions?*
5. *Assess changes in:*
  - thinking*
  - coping skills*
  - feeling of control*

*feeling of trust*  
*feeling of security*  
*meaning of life*

(Adapted from Burke, 1998)

While workers who are supporting people with learning difficulties will need to adapt the language in these questions, and perhaps spread assessment over a number of meetings, the answers that people give can suggest what kinds of supports and what kinds of counselling strategies might make a difference.

(ii) Choosing Appropriate Counselling/Support Strategies

Kennedy et al (1997), writing of women with intellectual disabilities who have suffered sexual assault, see no evidence that the therapeutic needs of women with intellectual disabilities are any different to those of other women, particularly since the effects of trauma are very much the same. It appears that, with adaptations to suit the person's levels of understanding, development, age and social environment, most practitioners working with people with learning difficulties use and modify a range of known counselling therapies. Kennedy et al believe that there is little indication that men or women with learning difficulties who have been victims of crime and trauma require altogether new counselling strategies, although workers and carers do adapt their communication styles, work at a slower pace, and are alert to the nature of the person's disability and how that might affect communication (see Appendix 2).

In the literature, writers seem to agree that the following are essential elements of post trauma work: building trust and ensuring safety, restoring self-control and self-esteem and capacity for relationships, educating the person about trauma reactions ('normalising'), attending to the person's overall health and social integration, and developing a concrete strategy for the person to deal with the effects of trauma (for example, "I can expect X and Y to happen and, when they do, I can do A and B and C and D to deal with them").

Where writers and practitioners sometimes diverge is over the question of whether the person experiencing post trauma difficulties needs to re-live or re-experience the trauma during professional counselling. While most seem to steer a middle path, some writers and practitioners endorse the more radical therapies of "flooding", where the person is encouraged to re-experience their memories of the trauma in a safe therapeutic environment. Van der Kolk (1996, 434-6), in a review of treatment outcome studies, concludes that "research strongly suggests the idea that exposure to memories of the trauma is an essential element of effective treatment", but cautions that the therapist needs to approach trauma related material gradually and sensitively since there can be adverse consequences and no guarantee of long term benefit. Therapists need to have sound clinical reasons to focus on the person re-living the trauma, and not do this for the sake of curiosity or voyeurism, or in the mistaken belief that it will be cathartic. Once the story has been told, therapists who know what information they need (and why) will be selective about going back to the 'black hole'.

It is important that any invasive or confrontational counselling techniques only occur within the context of qualified professional counselling, which is usually well outside the practice expertise of most disability workers, family members and carers. It is fair to say that most disability workers would avoid 'flooding' type techniques, especially when one of the real challenges of the work is helping people with learning difficulties 'move on', that is, moving past constant reiteration and re-experiencing of the trauma, and associated cycles of depression and despair.

(iii) 'Unsticking' Learned Patterns of Post Trauma Stress Reactions

Because people with learning difficulties who have suffered trauma may be expected to need a prolonged recovery period, may be likely to develop PTSD, and commonly find it difficult to 'move on', it is useful for workers to be aware of how the stuck patterns of PTSD develop and how people can take control of their post trauma reactions.

The following diagram (Burke, 1998) charts ten phases of the development of learned and stuck PTSD reactions. Aware of these phases, workers can help an individual break their pattern at Step 3, before the physiological reactions associated with the trauma 'kickstart' the powerfully destructive process of negative self-talk.



The following diagram (Burke, 1998) maps opportunities for support and counselling. As always, earliest possible intervention is the aim.

## **THE CYCLICAL NATURE OF PTSD EFFECTS**

Workers and carers use a variety of techniques to assist people take control of anxiety, panic and depressive reactions, as well as post trauma reactions. The post trauma literature gives many examples of helpful techniques: for example, Eastwell and Cheyne (1997), Winn (1994) and WWILD-SVP Service (1999) provide useful descriptions of group work methods, through a variety of media, and Herman (1992), Walker (1994), Raphael and Meldrum (1994), Van der Kolk (1996), Rosenbloom and Williams (1999) outline specific counselling strategies for individual work.

Whatever the preferred strategy, or mix of strategies, it is important that workers and their organisations appreciate the amount of time the work may take. In some circumstances, it may not be feasible for workers to spend the time that is legitimately required, in which case it may be best to seek out an appropriate referral rather than attempt what is beyond the limits of their work role, training and level of expertise.

Within a broad counselling and support strategy, Burke (1998) suggests a twelve step exercise that workers can assist people learn to put into action when they experience post trauma reactions.

*The person experiencing a post trauma reaction says:*

1. *I'm triggered.*  
*What has triggered me? Smell? Words? Atmosphere? People's attitude? etc.*
2. *I know I'm triggered because I know my physiological reactions.*
3. *I need to slow down my bodily responses*
4. *Breathe deeply - fill lungs and hold for 2 to 5 seconds, then slowly release.*
5. *Say STOP! Take it easy! (Think of a red STOP sign).*
6. *Give myself instructions (start positive 'self-talk' - stop negative self-talk).*  
*"Thanks, Head, for the warning!" (Don't chastise myself!)*  
*"I'll check it out - am I under real threat?" (I'll only move quickly if I'm under physical threat.)*  
*"I'll take control from here."*  
*"I'll take control of my body's reaction" (Keep breathing, settle self down.*  
*(When settled) "Okay, take it easy. Switch off. Stand down."*
7. *Concentrate on how I have controlled myself.*  
*e. g. I did [this, X or Y] and it worked.*
8. *Stop thinking about past events. (don't analyse myself when I'm uptight).*
9. *Think about positives I've done to counter negative self-talk.*  
*Get out my list of affirmations and read.*  
*Write a list of my successes, things I enjoy and am good at - study the list.*  
*Do this for 10 to 15 minutes.*
10. *Focus on an activity, and give myself explicit instructions*  
*e.g. Phone my friend/family member. Make dinner. etc.*  
*Talk in a normal calm voice.*
11. *Remind myself that I controlled the reaction - the reaction did not control me.*

12. *Look for a trend in how I managed this.*  
*Don't judge myself if I can't do it.*  
*Do it as many times and as often as I need.*  
*How many times have I been successful? (1 out of 10 = 10% improvement; 6 out of 10 = success more times than not.)*

There have been suggestions that workers might be able to video or audio record this exercise for people to practise when they are not with their worker or carer.

### **(c) Building Community Connections**

An essential part of healing and recovery from trauma is re-connecting to community, to the web of relationships that form the cocoon of safety for the person recovering from trauma. The problem for people with learning difficulties is that they may have few community support networks at the best of times, let alone after an isolating experience of trauma.

Based on their work at Hornsby Challenge, van Dam and Cameron McGill (1995) list a number of factors which can work against people with learning difficulties developing friendships in groups and community: institutionalisation, staff attitudes [e.g., over or lack of protection], substitution of paid staff as 'friends', institutional thinking (e.g., setting scheduled activities to fill up a person's time), too little or too much support to attend groups, too much focus on the person's rather than the group's relationships, inappropriate groups, inappropriate behaviours. Hornsby Challenge employs specific staff to be 'social networkers': these staff research the person's interests, contact and visit potential groups, go with a person on their first visit(s), facilitate initial interactions in the group, and eventually 'fade out'.

Workers, families and carers who work with people who have suffered trauma as a victim of crime may need to be similarly purposeful and strategic.

Barringham and Barringham, in conjunction with the Anglicare Mental Health Network (1998), have outlined the following strategies for workers to assist people with mental health problems make community connections. With modification, they may enable workers to assist people with learning difficulties re-establish their lives in community.

#### Workers assisting people connect with community need to:

- *Be open to listen, trust and accept others and their needs.*
- *Break the cycle of isolation (look for ways to bring the person into everyday contact with a range of other people e.g. local newsagent, library, church, community centre, hobby group, club).*

- *Search for and focus on the person's "ticket" out of isolation (what strengths and talents the person can offer to their community).*
- *Ask community people if they'd be willing to make a connection. [Don't wait for the perfect match!]*
- *Trust the wisdom of the community - brainstorm with others.*
- *Strengthen existing relationships.*
- *Use your imagination - marginalised people can be included and accepted.*
- *Find and work with 'bridge builders' - people who have many community connections.*
- *Consider the importance of rhythms and routines - it is often good to do things at the same time at the same place.*
- *Recognise the importance of the simple and ordinary [e.g., celebrate the person meeting a neighbour].*
- *Give people the space to sort out differences and work out issues. [Don't always step in to sort things out.]*
- *Don't look for an ironclad guarantee of success (there may be no perfect solution).*
- *Be willing to let go [let things take their course].*
- *Know the bottom line [e.g. how much money there is to spend for this work].*
- *Focus on opportunities for relationships rather than on activities.*
- *Encourage everyone [people can easily become reluctant or discouraged].*
- *Keep your eyes open for opportunities [e.g. keep your eye on the local paper].*
- *Know the community [who is where, who does what and when - talk to community leaders and bridge builders].*
- *Work with moments of openness [people are more open to relationships at some times rather than others].*

### **3. PRACTICE PRINCIPLES : POST TRAUMA SUPPORT FOR PEOPLE WITH LEARNING DIFFICULTIES**

Razza (1999), writing of clinical work with people with intellectual disabilities who have been victimised, emphasises the following: building trust, showing respect, and paying attention to a person's feelings about what has occurred, in particular, noting anxiety or depression as a result of what they have experienced. She finds that people with intellectual disabilities are more likely than others "to experience irritable rather than sad moods when depressed" (65). Similarly, because people with intellectual disabilities commonly have low self-esteem, they are more likely than others to blame themselves for what has occurred. Razza, as others, reminds us that trauma occurs across all the senses, and that responses should likewise attend to all dimensions: "somatic, emotional, cognitive, behavioural and characterological" (64).

The twelve principles below have been formulated to guide professional trauma counsellors working with people suffering PTSD. We suggest that these principles, in conjunction with the practice principles of effective communication (Appendix 2), must also guide support work with people with learning difficulties who have experienced trauma as victims of crime.

- 1. Rapport, trust and empathy are vital.**
- 2. Empowerment of the individual is the essential aim.**
- 3. Educate [the victim] about the predictable effect(s) of trauma and reactions.**
- 4. Telling the story is vital (not to satisfy the worker's curiosity, but to hear the details that have important meaning for the person).**
- 5. Discover the meaning of the traumatic event and its many parts.**
- 6. Remember that differing situational stresses can trigger different aspects of the meaning.**
- 7. Work towards a positive redefinition of the person as a survivor of trauma.**
- 8. The traumatic event can't be erased from the person's history and memory, but counselling can reduce the intrusiveness of the trauma.**
- 9. Link unresolved emotional issues from the past (e.g. from family of origin).**
- 10. Look for ways to highlight and keep alive the positive events/changes that take place every day in the midst of the trauma experience.**

**11. Manage the interference of PTSD symptoms in social, family and work relationships and every day living.**

**12. "The more I can manage, the more I can make a difference." A growing repertoire of normal behaviours indicates increasing influence over trauma reactions.**

(Adapted from Burke, 1998.)

In conclusion, let us listen to the voices of people with learning difficulties themselves. They have told us what, for them, does and doesn't help.

*"I feel good when people take the time to listen and understand me.*

*I feel supported when people take the time to explain slowly and in different ways if I don't understand the first time.*

*I feel unimportant when people don't try to understand me and how I see things.*

*I feel hurt when people go too quick.*

*I wouldn't go back there when people use words I don't understand." (Community Living Program Education Manual, 1998).*

They think that workers should:

*"talk to the [person] and ask them how they can be better*

*go at our pace - take time*

*don't talk for us - let us talk for ourselves*

*believe us and our experiences*

*think about what it might be like for a [person] with intellectual and learning disabilities and be in our shoes for a day."*

(WWILD - Sexual Violence Prevention Service, Info Sheets, 1999)

The practice wisdom we have brought together here has come from a scan of relevant literature and from interviews and discussions with colleagues who are trauma counsellors, some of whom have worked with people with learning difficulties and some of whom have not.

The document is not intended to give a comprehensive picture of trauma support, which is a field of practice in its own right. However, because there seems to be little literature that directly addresses post trauma support for people with learning difficulties who have been victims of crime, we have drawn on some of the insights of the trauma counselling field in order to suggest strategies, or adaptations of strategies, that may be useful in work with people with learning difficulties. In this sense, it is not a static document, but rather a record of learnings thus far and an invitation to others to contribute their knowledge and practice wisdom.

## APPENDIX 1

*Linda Winn has outlined the diagnostic criteria of Post Traumatic Stress Disorder, as determined by the American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders (1987):*

1. The experience of an abnormal stressor.
2. The re-experiencing of the event (flashbacks).
3. Avoidance behaviour. (The sufferer seeks to avoid situations which may trigger memories of the event.)
4. Increased arousal to stimuli (e.g. certain smells, sounds, sights associated with the incident may provoke a physical reaction such as nausea, panic etc.).
5. A duration of one month.

In cases of PTSD the following are in evidence:

1. A recognised stressor. (An incident to which the current difficulty is directly attributable.)
2. A re-experiencing of the event.
3. A numbing of responsiveness (this can be very distressing, for example, recalling a motor accident but only seeing empty vehicles with no helpers or others involved).

In addition, at least two of the following symptoms were not present before the traumatising event:

1. Hyper-alertness.
2. Sleep disturbance.
3. Survivor or performance guilt ("I should have done that differently").
4. Memory or concentration problems.
5. Avoidance behaviour.
6. Intensification: a widening of tension and anxiety to other areas.

*Linda Winn (1994) Post Traumatic Stress Disorder and Dramatherapy: Treatment and Risk Reduction, Jessica Kingsley.*

## APPENDIX 2: Principles of Effective Communication with People with Learning Difficulties

- **listen with respect:** affirm the value of what the person has to say; show interest in what the person says; share condemnation of exploitation, abuse etc. they may have suffered; be aware of non verbal communication; treat people age appropriately;
- **affirm safety and choice:** be clear about worker/friend boundaries; support person's right to make decisions;
- **time and pace communication to suit the person:** be aware of differing concentration spans; take breaks when necessary, or plan for shorter meetings; go over material as many times as needed; be clear about time boundaries for meetings; be patient; allow time for silences;
- **check understanding:** check that people understand the broad purpose of the communication; avoid jargon and abstract terms; use single concept sentences; use clear, plain, concrete language; be aware that people may say they understand in order to please or to mask their disability, or may try to guess what is the 'right' answer; ask people to say in their own words what they have understood;
- **ask questions in ways that maximise the person's participation in discussion:** use open-ended questions (direct questions to elicit information); avoid loaded questions; be aware of difficulties with concepts of time; ask for clarification if you are unsure; be willing to challenge (e.g. myths and stereotypes); offer opportunities for the person to ask questions; use 'feeling faces' to help people name emotions;
- **give information visually as well as verbally:** for example, use or draw pictures and diagrams, collages, videos, brochures etc.; create scenarios, role plays; do not assume people have all the information they need.

*(Adapted from Community Living Program "Education Manual" and WWILD - Sexual Violence Prevention Service InfoSheets)*

## APPENDIX 3: USEFUL RESOURCES

### (a) Literature

*As noted above, there is an extensive literature on trauma counselling. The following texts and materials are those which we found relevant for this Project. We have found these and other materials at the State Library, the Community Resource Unit library, Endeavour Foundation library, and University of Queensland library.*

Aeillo, D. (1986) "Issues and Concerns Confronting Disabled Assault Victims: Strategies for Treatment and Prevention", Sexuality and Disability, 7, 96-101.

Baladerian, N. (1994) "Intervention and Treatment of Children with Severe Disabilities Who Become Victims of Abuse", Developmental Disabilities Bulletin Vol. 22, No. 2:93-99.

Barringham, Neil and Penny (1999) "A Place to Belong: Anglicare Mental Health Network". Training materials. Brisbane.

Brown, Sandra L. (1991) Counselling Victims of Violence, American Assoc. for Counselling and Development.

Bruckner, Debra F. and Johnson, Peter E. (1987) "Treatment for Adult Male Victims of Childhood Sexual Abuse", in Social Casework: The Journal of Contemporary Social Work, February.

Burke, Doug (1998) "Trauma Training Package". Unpublished. Brisbane.

Carmody, Moira (1991) "Invisible Victims: Sexual Assault of People with an Intellectual Disability", Australia and New Zealand Journal of Developmental Disabilities, 17, 2, pp 229-236.

Chenoweth, Leslie (1993), "The Mask of Benevolence: Cultures of Violence and People with Disabilities", in Bessant, Judith et al (eds) Cultures of Crime and Violence: The Australian Experience, La Trobe University Press.

Community Living Program (1998) Working with People with a Learning Disability: A Manual in Two Parts, Community Living Association Inc., Nundah.

Conway, R. Bergin, L. and Thornton, K. (1996) Abuse and Adults Living in Residential Services, National Council on Intellectual Disability (NCID) and Australian Society for the Study of Intellectual Disability (ASSID).

Devilly, Grant J. and Spence, Susan H. (1999) "The Relative Efficacy and Treatment Distress of EMDR and a Cognitive-Behavior Trauma Treatment Protocol in the Amelioration of Posttraumatic Stress Disorder", in Journal of Anxiety Disorders, Vol 13, No 1-2, pp. 131-157.

Downes, M. (1982) "Counseling Women with Developmental Disabilities", Women and Therapy, 1 (3), 101-109.

Eastwell, C. and Cheyne, K. (1997) Making Waves: Violence against Women with Learning Disabilities. A Resource Manual for Workers, City Prevention of Domestic Violence Program, Brisbane.

Figley, C. (ed) (1995) Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatised, Washington Square, London.

Grossman, David (1999), "Killology". Interview, Background Briefing, ABC Radio, 2/5/99.

Herman, Judith Lewis MD (1992) Trauma and Recovery, BasicBooks.

Johnson, K. Andrew, R. and Topp, V. (1988) Silent Victims: A Study of People with an Intellectual Disability as Victims of Crime, Office of the Public Advocate, Victoria.

Kennedy & Co. (1997) Equity: A Kit Developed for the Sexual Assault Services of New South Wales (Draft), New South Wales Department of Health.

Kleber, R. Figley, C. et al (eds) (1995) Beyond Trauma: Cultural and Social Dynamics, Plenum Press: London.

Law Reform Commission NSW Issues Paper 8 and Report 3 (1992) People with an Intellectual Disability and the Criminal Justice System.

Matson, J. (1983) "Depression in Mentally Retarded Persons: Research Findings and Future Directions", Australian and New Zealand Journal of Developmental Disabilities, Vol. 9, No. 4: 185-190.

Ochberg, Frank M. (1993) "Posttraumatic Therapy", in John Wilson and Beverley Raphael (eds) International Handbook of Traumatic Stress Syndrome, Plenum Press.

Office of the Public Advocate (1988) Silent Victims: A Study of the Difficulties Encountered by Victims of Crime Who Are Intellectually Disabled, Melbourne.

Raphael, Beverley and Meldrum, Lenore (1994) "Helping People Cope with Trauma", in Rod Watts and David de L. Horne (eds) Coping with Trauma: The Victim and the Helper, Australian Academic Press, Bowen Hills.

Razza, Nancy (1999) "A Question of Abuse: Talking with Persons Who Have MR/DD about Their Experiences with Victimization. Part 2", Mental Health Aspects of Developmental Disabilities, Vol 2, No. 2: 64-68.

Rosenbloom, Dena and Williams, Mary Beth (1999) Life After Trauma: A Workbook for Healing, Guilford Press.

Sobsey, Dick et al (1991) Disability, Sexuality and Abuse: An Annotated Bibliography, Paul H. Brookes Publishers.

Sobsey, Dick (1994) Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance? Paul H. Brookes Publishing Co.

van Dam, Trudy, and Cameron-McGill, Fiona (1995) "Developing Relationships - That's What Friends Are For!" Interaction, Vol. 8, Issue 4. National Council on Intellectual Disability.

van der Kolk, Bessel (1996) "A General Approach to Treatment of Posttraumatic Stress Disorder", in Bessel van der Kolk (ed) Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society, Guildford Press.

Walker, Lenore (1994) Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist, American Psychological Assoc., Washington D.C.

Williams, Brian (1999) Working with Victims of Crime: Policies, Politics and Practice, Jessica Kingsley.

Wilgosh, L. (1993) "Sexual Abuse of Children with Disabilities: Intervention and Treatment Issues for Parents", in Developmental Disabilities Bulletin Vol. 21, No. 2: 1-12.

Williams, Christopher (1995) Invisible Victims: Crime and Abuse against People with Learning Disabilities, Jessica Kingsley Publishers.

Winn, Linda (1994) Post Traumatic Stress Disorder and Dramatherapy: Treatment and Risk Reduction, Jessica Kingsley Publishers.

WWILD-Sexual Violence Prevention Service (1999) Group Work Manual. Unpublished.

## **(b) Specialist Services**

*There are specialist services and practitioners to assist people who have been victims of sexual abuse, people who require trauma counselling, and people who wish to pursue their rights through the courts. The list below is a beginning list of available services and practitioners, to which you may want to add your own preferred/local service contacts.*

Australasian Critical Incident Stress Association  
(Queensland contact- Lenore Meldrum 3266 3929)  
*Can provide names of Queensland trauma counsellors*

Australasian Society for Traumatic Stress Studies  
(Queensland contact - Elizabeth Wilson-Evered 0413 18 19 66)  
Neil and Penny Barringham are available to train community organisations to assist people build community connections.  
tel: 3217 2522

Doug Burke. Trainer and Trauma Counsellor. tel: 0419 963 142.

Immigrant Women's Support Service: 3846 5400

Murrigunyah Aboriginal and Torres Strait Islander Women's Corporation Inc. : 3290 4254

Queensland Program of Assistance to Survivors of Torture and Trauma:  
3391 6677

Victims of Crime Association: 3252 5057  
*contact Sue Leckie*

Victim Support Service: 3834 1624 (or 3239 6807??)  
*contact Mel Shelley*

WWILD-Sexual Violence Prevention Service - 07 3262 9877  
*contact Cathy Davis*

Zig Zag Young Women's Resource Centre - 07 3843 1823.

Ester Trust – Abuse Prevention by Professionals and Carers. 07 3844 9122

## **To be added to second diagram by Burke**

### APPROPRIATE TYPE OF INTERVENTION DURING PTSD CYCLE

- A. Crisis Intervention
- B. Change Oriented Counselling
- C. Change Oriented Counselling (most effective with trusted partner or counsellor)
- D. Point at which sources of support become sources of stress