# Module 2 – Responding to Disclosure

## Topic 1. What is Sexual Violence?

### *1. THE SEXUAL RIGHTS OF PEOPLE WITH INTELLECTUAL DISABILITY*

Topic 1 is concerned with sexual violence against people with intellectual disability. However, it is important to note that alongside the right to protection from sexual violence, people with intellectual disability have a human right to sexual expression. For people with intellectual disability, both of these rights are often infringed. It is important that our efforts to ensure people with intellectual disability are safe from experiences of sexual violence we do not restrict their rights to human relationships and sexual expression.

The sexuality and sexual expression of people with intellectual disability are often viewed negatively (by other people in their lives and society in general) in terms of risk, disapproval, fear, and as something to be controlled. Historically, negative views about the sexuality of people with intellectual disability have resulted in practices such as forced sterilisation.

Today, negative views underpin people's continued exclusion from sex and sexuality education. Research demonstrates people with intellectual disability have limited sexual knowledge in comparison to the general population, particularly in relation to sexually transmitted diseases, sexual health, safer sex practices, legal issues, and contraception (McGuire & Bayley, 2011). Many people with intellectual disability do not receive any sex education. For those who do receive sex education, the information is not presented in ways people can understand; or is presented as a "one off" instruction, rather than an ongoing discussion that is revisited and reinforced over time. Lack of knowledge and understanding of sex and sexuality increases people's risk of abuse and exploitation.

Negative views about the sexuality of people with intellectual disability restrict their human rights to relationships and sexual expression. Research demonstrates that "people with intellectual disability want to express their sexuality and have relationships, but experience a range of barriers in doing this" (Frawley, O'Shea & Willis, 2009). Lack of privacy for intimacy and sexual expression in residential settings can result in people using isolated public or semi-private spaces to be sexually active (Hollomitz & The Speakup Committee, 2008). Negative views and restrictions on sexual

relationships can force people with an intellectual disability to conduct their sexual lives in secret, increasing the risk of abuse and exploitation.

## *2. WHAT IS SEXUAL VIOLENCE?*

Sexual violence is any sexual activity to which a person does not, or cannot, consent. 'Sexual violence' does not necessarily mean the person was physically injured during the assault. It is still a form of violence. Acts of sexual violence include:

- Rape (penetration)
- Touching, forcing someone to touch
- Indecent exposure
- Harassment and sexual innuendo
- Forcing someone to look at pornography
- Watching someone receive personal care (for example, washing or using the toilet) for sexual gratification

## *3. UNDERSTANDING CONSENT TO SEXUAL ACTIVITY*

Section 348 of the Criminal Code (Qld) 1899 defines consent to sexual activity as follows -

(1) Consent means consent freely and voluntarily given by a person with the cognitive capacity to give the consent.

(2) A person's consent to an act is not freely and voluntarily given if it is obtained—

(a) by force; or

(b) by threat or intimidation; or

(c) by fear of bodily harm; or

(d) by exercise of authority; or

(e) by false and fraudulent representations about the nature or purpose of the act; or

(f) by a mistaken belief induced by the accused person that the accused person was the person's sexual partner.

***Age of Consent (Children and Young People)***

"According to criminal law in Australia, the age of consent refers to the age a person is considered to be capable of legally giving informed consent to sexual acts with another person. When an adult

engages in sexual behaviour with someone below the age of consent, they are committing a criminal offence (child sexual abuse)…In Queensland, the age of consent for anal sex (referred to as sodomy in legislation) is 18 years of age, while the age of consent for all other sexual behaviour (described as carnal knowledge) is 16 years of age" (Australian Institute of Family Studies, 2016).

### *4. COGNITIVE CAPACITY TO MAKE SEXUALITY-RELATED DECISIONS (ADULTS)*

There is no clear definition of cognitive capacity to consent to sexual activity in Queensland, however, the presence of cognitive impairment does not preclude a person from having capacity to consent (Allens & Queensland Advocacy Incorporated, 2014).

The Queensland Law Society Handbook for Practitioners on Legal Capacity (Allens & QAI, 2014) outlines the following basic principles of law regarding capacity:

"(a) all adult persons are presumed to have capacity to make all decisions unless there is evidence to rebut the presumption; (b) capacity is time-specific, domain-specific and decision-specific, meaning at a given time a client may have capacity for some decisions but not others; (c) the capacity to make a decision must be distinguished from the content of the decision itself, meaning 'bad' decisions are not indicative of impaired capacity; (d) capacity should not be assessed solely on the basis of appearance, age, behaviour (including communication style), disability or impairment; (e) capacity may be increased with appropriate support; and (f) substituted decision making is a last resort."

"Capacity to consent" should be considered a fluid concept. It can be influenced positively or negatively, by the presence or absence of things such as information, support, threat, or coercion. Research demonstrates ongoing sex education and higher IQ increase potential for sexual consent capacity in people with intellectual disability (Murphy & O'Callaghan, 2004; McGuire & Bayley, 2011).

### *5. KNOWLEDGE FOR INFORMED CONSENT*

Whilst there is debate as to the nature and scope of knowledge required for a standard of informed consent, the following areas of knowledge are considered important and provide a framework for supporting people with intellectual disability to make informed decisions about sexual activity:

a) Basic sexual knowledge of body parts, sexual relations and sexual acts;

b) Knowledge of the potential consequences of sexual relations, including sexually transmitted diseases and pregnancy;
c) An understanding of appropriate sexual behaviour and the context for this;
d) An understanding that sexual contact should always be a matter of choice;
e) The ability to recognise potentially abusive situations;
f) The ability to show skills of assertion and reject unwanted advances (Murphy & O'Callaghan, 2004).

**References**


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## Topic 2. The Trauma Effects of Sexual Violence

### *1. TRAUMA*

Sexual violence is a traumatic event. The word ‘trauma' originates from the Greek term for ‘wound'. Very frightening or distressing events may result in a psychological wound that causes difficulty in coping or functioning normally following the event or experience. Traumatic events can be life threatening or involve a significant threat to physical or psychological wellbeing. Experiences and events that can lead a person to experience psychological trauma include:

- Acts of violence such as an armed robbery, war or terrorism
- Natural disasters such as bushfire, earthquake or floods
- Interpersonal violence such as rape, child abuse, or suicide of a family member or friend
- Involvement in a serious motor vehicle or workplace accident.
- Other less severe but still stressful situations can also trigger traumatic reactions in some people (Australian Psychological Society, 2016).

### *2. EFFECTS OF SEXUAL VIOLENCE (TRAUMA)*

People with intellectual disability experience the same effects of sexual violence and abuse as all victims and survivors. At the same time, the experience of intellectual disability presents additional factors that can impact the effects of abuse. The effects of sexual violence and abuse include emotional, psychological, physical, and behavioural effects.

**Emotional Effects (Feelings)**

- Feelings of powerlessness and loss of control
- Guilt or self-blame
- Embarrassment or shame
- Anger
- Fear
- Alienation or isolation
- Loss of confidence or reduced self-esteem
- Emotional numbness

**Psychological Effects (Thoughts)**

- Anxiety
- Sleep disturbance

- Depressive symptoms and/or major depressive episodes
- Post-traumatic stress syndrome
- Flashbacks - an experience of reliving a past traumatic event as if it is occurring now. They usually include vivid imagery and extreme emotions; they can last for seconds or can continue for hours. A dissociated state can last for several days (Laurel House, 2015).
- Protective Denial - It is very common for survivors to repress some or all of the abuse as a way of coping with the abuse and being protected from the intense emotional pain experienced when the abuse was taking place. Sometimes the gaps in memory protect the survivor from recalling the details of the abuse, and in other situations from remembering that any type of abuse occurred at all (Department of Human Services Victoria, 2013).

**Physical Effects**

- Short-term physical effects of sexual violence include physical injury, pregnancy, sexually transmitted disease.
- Long-term physical health problems associated with a history of sexual trauma in women include irritable bowel syndrome, abdominal pain, vaginal pain, breast pain, headaches, musculoskeletal pain, pelvic pain and pelvic inflamamatory disease, painful periods (dysmenorrhoea), abnormally heaving or prolonged bleeding (menorrhagia), sexual dysfunction, non-menstrual vaginal bleeding or discharge, rectal bleeding, bladder infection, painful or difficult urination (dysuria) (Pugh, Goodwach & Coles, 2012)
- It is also important to note there may be no signs to indicate that sexual abuse has occurred.

## *3. INDICATORS OF SEXUAL ABUSE*

Understanding the effects of sexual violence can help us recognise indicators of sexual abuse. The most reliable indicators of sexual abuse are:

- Disclosure
- Physical injuries
- Significant behaviour changes

It is important to note that the presence of particular signs or indicators does not always mean sexual abuse has occurred – something else may be troubling the person. Likewise, it is important to remember there may be no visible signs to indicate that sexual abuse has occurred.

## Behavioural Indicators

Behavioural changes are a common way to express distress following an experience of sexual violence or abuse (for victims with and without intellectual disability). However, for people with an intellectual disability, behaviour changes can be overlooked or attributed to their disability. It is very important to pay attention to any behaviour changes and explore why these might have occurred. For people who have restricted communication skills, it is especially important to involve significant others who may be better positioned to notice behaviour changes and/or understand people's attempts to communicate experiences of abuse.

**Behavioural signs that shouldn't be ignored are:**

- Disturbed sleep patterns and/or distress about going to bed
- Angry or violent outbursts
- Loss of personal modesty
- Changes in sexual behaviour and/or inappropriate behaviour
- Fear of going out or being alone
- Reactions to specific people or to a specific gender
- Use of sexual language not used before
- New obsessive behaviours
- Self-harm
- Changes in people's attitude to personal assistance during bathing
- Changes to incontinence.
- Avoidance of preventative health care such as pap smears and breast examinations (Pugh, Goodwach & Coles, 2012)

## References


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## Topic 3. Vulnerability to Sexual Violence

### *1. VULNERABILTY TO SEXUAL VIOLENCE*

Decades of national and international research demonstrates people with intellectual disability are at increased risk of sexual violence and abuse:

- 50% - 99% of people with an intellectual or psychosocial impairment will experience sexual assault in their life time (French, 2007).
- Sexual assault against people with intellectual disability is more likely to be repeated or continuing, and is more likely to be severe or violent, compared with the general population (French, 2007).

As in the general population, sexual violence against people with intellectual disability is gendered:

- Women and girls with intellectual disability are the overwhelming majority of victims of sexual assault.
- The majority of women with intellectual disability have been sexually exploited by the time they reach adulthood (Keilty & Connelly, 2001).
- At the same time, men and boys are also vulnerable to sexual violence and abuse. Men with an intellectual disability and experience a greater risk of victimisation than men in the general population (Murray & Powell, 2008).

### *2. UNDERSTANDING VULNERABILITY*

Multiple, intersecting factors increase the vulnerability of people with intellectual disability to sexual violence and abuse. These factors are well described in this statement by the NSW Attorney General's Department (2007):

*"People who have a cognitive impairment are more vulnerable to sexual assault and abuse because they depend on others for assistance with daily life. Other factors that are likely to increase vulnerability to criminal victimisation are: their impaired judgment, deficits in adaptive behaviour, accompanying physical disabilities which may inhibit the person conveying sexual victimisation, the high risk environments in which they live and work, their lack of knowledge about their rights, and the attraction of some abusers to environments in which they will encounter vulnerable victims".*

Understanding the range of personal and social factors that increase the vulnerability of people with intellectual disability to sexual violence and abuse can assist service providers and support workers

to proactively identify and respond to risks (for example, through providing tailored sexuality education and teaching 'protective behaviours'). HOWEVER, a singular emphasis on vulnerability places the responsibility for stopping sexual violence and abuse in the hands of the individual themselves, and neglects the wider social responsibility to value the lives and experiences of people with intellectual disability; and to 'detoxify' environments that make people with disability vulnerable to sexual assault (French 2007).

**Personal factors** (including socialised behaviours) demonstrated by many people with intellectual disability can be exploited by perpetrators and can increase people's vulnerability to sexual violence and abuse, including:

- A desire to please others.
- High levels of compliance and acceptance of what is done to them by others, especially authority figures.
- A belief that someone else should decide whether or not they should have sex/be sexual.
- Difficulty or inability to negotiate sexual relationships (for example, consenting to some sexual activity but not all).
- Difficulties with communication can make it hard for people to report abuse, and may be exploited by perpetrators.

**Social factors** typical of the lives of many people with intellectual disability can increase people's vulnerability to sexual violence and abuse, including:

- Limited or no sexual education, resulting in restricted knowledge and understanding of sex, sexuality and abuse.
- Messages from others that sexual behaviour is not okay, resulting in secrecy which increases risk and risky behaviours.
- Congregation in 'closed' environments, including accommodation, education and employment settings with a lack of external oversight, where abuse may be perpetrated unseen by others.
- Reliance on others for intimate personal care needs, providing opportunities for perpetrators of sexual violence to have intimate contact with victims that may be used to mask abuse.
- Limited access to supportive relationships, and having no one to discuss sex and relationships with.
- Limited choice of partners and friends due to isolation and the lack of social opportunities.
- Poverty and use of sex to meet every day needs (for example, transport, food, cigarettes).

**Social myths and attitudes** about people with intellectual disability can also increase their vulnerability to sexual violence and abuse. For example, beliefs that:

- *People with intellectual disability are like children, and/or are asexual.*
- *People with intellectual disability do not attract sexual attention because they are sexually undesirable; and/or no-one would take advantage of someone with a disability.*
- *People with intellectual disability live in institutions where they are protected.*
- *People with intellectual disability need to be protected or prevented from sexuality activity, and this can be achieved by withholding sexual education and/or sterilization.*

**Social myths and attitudes** can minimise or deny people's experiences of sexual violence and abuse. For example, beliefs that:

- *People with an intellectual disability are unable to distinguish fantasy from fact.*
- *People with intellectual disabilities do not feel hurt by abuse or exploitation because they cannot fully understand what happened.*
- *People with disabilities should be grateful for any sexual contact, as no one would want to have sex with them.*

**Social myths and attitudes** can blame people for experiences of sexual violence and abuse. For example, beliefs that:

- *People with an intellectual disability behave in a way that invites or provokes victimization.*
- *People with intellectual disability are sexually insatiable.*

**Social myths and attitudes** can restrict victims' access to justice after experiences of sexual violence and abuse. For example, beliefs that

- *People with intellectual disability are not competent to give evidence in court.*
- *People with intellectual disability would be overwhelmed by the legal process therefore it is not in their best interests to take legal action.*

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## Topic 4. Perpetrators of Sexual Violence

### *1. WHO PERPETRATES SEXUAL VIOLENCE AGAINST PEOPLE WITH AN INTELLECTUAL DISABILITY?*

People with an Intellectual Disability are vulnerable to victimisation by ANYONE. Abusers can include significant others, acquaintances and strangers, but in most cases the offender is known to the person (as is the case for the majority of victims of sexual violence, with and without a disability). The majority of offenders are male, however women can be abusers too.

- *Significant others* can include family members, intimate partners, friends, support workers, carers.
- *Acquaintances* can include co-residents, community members, bus or taxi drivers, contacts on social networking sites.
- *Strangers* can include someone they just met (for example, at the bus stop or train station); or someone acting "friendly". For this reason, people with intellectual disability may think of or describe the offender as their "friend".

### *2. GROOMING*

Many perpetrators will go through a process of 'grooming' someone to be vulnerable to abuse. Grooming is a defined as "a conscious, purposeful, and carefully planned approach used by the offender to gain access to the person, gain the person's trust and compliance and maintain the person's secrecy to provide opportunities to abuse and reduce the likelihood of being reported or discovered. This process is thought to strengthen the offender's abusive pattern of behaviour, as it may be used as a means of justifying or denying their actions" (National Society for the Prevention of Cruelty to Children, 2016).

#### *Grooming Steps*

The US National Centre for Victims of Crime (2012) describes common "grooming steps" used by perpetrators of child sexual abuse. Some or all of these practices may also be used in abuse of other vulnerable people, including people with intellectual disability (). Whilst these steps are described here as a linear process, in real life perpetrators may use some or all of these behaviours at the same time; in a different order; and/or over a short time (e.g. minutes or hours) or a longer period of time (e.g. weeks and months).

1. **Targeting the victim**

Any vulnerable person may be a potential victim. Perpetrators may target victims with certain characteristics to facilitate the crime (such as cognitive impairment). As discussed in Topic 1, a range of personal and social factors heighten the vulnerability of people with intellectual disability to sexual abuse. Perpetrators often exploit these factors – for example, cognitive impairment and increased suggestibility; loneliness and desire for social connection; poverty and lack of accommodation and/or money for food, cigarettes; high visibility in the community and readiness to make contact with strangers.

2. **Gaining trust and access**

Perpetrators may gain access to potential victims through care or service delivery environments (for example, personal carer, support worker, co-resident, or service user); transport services (for example, bus or taxi drivers); or in the community. Perpetrators may also gain trust and access through informal relationships (for example, family member, friend, neighbour, acquaintance). In some cases perpetrators may offer the victim special attention, gifts or treats to gain their friendship and trust.

3. **Filling a need (or exploiting a need)**

Perpetrators may manipulate the relationship to appear *they are the only one who can meet the victim's needs*, including emotional needs for companionship and affection; material needs such as accommodation, money, food, and transport; and personal care needs. Perpetrators may also exploit their victim's empathy and desire to be valued by suggesting *their victim is the only one who can meet the perpetrator's needs*. For example, a perpetrator may tell their victim they *"need them"* or that their victim is the only person who *"understands them"*.

4. **Isolating and creating secrecy**

Perpetrators may seek to take victims away from others who might witness abuse – for example, on outings or places on their own. Or they may restrict people's access to other relationships, for example, family, friends, services. Perpetrators may seek to create a "special connection" with victims through personal contact, emails or text messages; and may instruct victims not to tell other people about their "special relationship" who will try to stop it. Perpetrators may tell victims they are worthless or undesirable, and lucky to have their relationship with the perpetrator because nobody else wants them.

5. **Lowering inhibitions and sexualising the relationship**

This can happen very quickly or take place over a period of time. In some cases the perpetrator may initiate physical contact with the victim that is not overtly sexual at first (for example, pat on the knee, arm around shoulder). They may gradually introduce more sexualised touching by breaking down inhibitions and desensitising the victim. The perpetrator may seek to influence the victim's perception of the sexualised behaviour by telling them "this is nice" or "what friends do". In other cases the perpetrator may engage in sexually abusive practices during the delivery of intimate personal care (for example, toileting and showering). Some perpetrators will simply use force and coercion.

6. **Maintaining control**

Perpetrators rely on the secrecy of the relationship to keep it going and ensuring the victim does not reveal the abuse (because of fear, lack of knowledge that something is wrong, lack of supportive relationships to seek help from, and/or communication difficulties). Perpetrators will exploit victims fears (for example, by telling them that others will not believe them; they are to blame for the abuse; or that they wanted the abuse to happen "you liked it". Where people consented to one activity (e.g. kissing) but not another (intercourse) they can be particularly vulnerable to feeling the abuse was their fault, and perpetrators may exploit this.

Perpetrators may threaten victims to maintain secrecy, for example, by saying that other people will be angry and blame them if they tell; that they will be punished for the abuse. Perpetrators may threaten physical violence to the victim or their significant others, or self-harm/suicide by the perpetrator; or they may threaten a loss of needed resources (for example, accommodation); or a loss of valued relationships (for example, contact with children, or family members or friends).

**References**

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## Topic 5. Responding to Disclosure of Sexual Violence: Guiding Principles

### *1. TYPES OF DISCLOSURE*

As for any victim/survivor of sexual violence, people with intellectual disability may disclose experiences of sexual violence in different ways. Research identifies 6 different types of disclosure which may occur individually or in combination (Breckenridge, Cunningham & Jennings, 2008):

1. Purposeful – an intentional report
2. Accidental – an unintentional report or revelation
3. Elicited/prompted - in response to being questioned or asked
4. Behavioural- disclosure through behaviour, non-verbal communication and indirect verbal clues
5. Triggered - here disclosure is triggered by associations or life events following a period where there was no recall of the abuse.
6. Intentionally withheld - deliberate choices not to disclose, including false denial

When working with people with intellectual disability it is especially important to note that disclosure of sexual abuse can occur through direct communication (verbal and non-verbal methods used by the individual) and indirect communication (for example, behaviours).

### *2. TIMING OF DISCLOSURE*

It is a person's right to choose if and when they disclose an experience of sexual violence. Do not judge people for their choice. It is also important to remember there are many barriers to disclosing experience of sexual violence, which we will discuss shortly. Disclosure of sexual abuse can happen at any time, including:

- *During the period of time that the abuse is occurring* (where abuse is ongoing over a period of weeks, months, years)
- *Immediately after the abuse has ended* (including after a single experience of assault or at the end of an ongoing period of abuse)
- *Years later*. Many victims/survivors of sexual violence, including people with and without a disability, do not disclose their experiences for many months or years after the event. For example, the recent Royal Commission into Child Sexual Abuse found it takes 22 years on average for men to disclose childhood sexual abuse (Commonwealth of Australia, 2014, p. 158). Research demonstrates many children do not disclose abuse at all during childhood (London, Bruck, Ceci & Schuman, 2005; AIFS, 2015)

### *3. DISCLOSURE TRIGGERS*

Disclosure of past experience of sexual assault is often triggered by life changes or events, including:

- The death of a perpetrator
- Disclosure by a sibling
- Hearing about other abuse by the same perpetrator
- Health problems
- Legal processes
- Perpetrator moving back from interstate
- Children, nieces or nephews approaching the age when the person was abused
- Relationship or marriage breakdown
- Pregnancy
- Giving birth
- A new relationship (Breckenridge, Cunningham & Jennings, 2008)

### *4. BARRIERS TO DISCLOSURE*

It is important to understand the many "barriers to disclosure", including:

- Grooming – threats & rewards
- Fear of consequences
- Shame and confusion
- Low conviction rates
- Not knowing anything is wrong. People with an intellectual disability may have a lack of
- knowledge about their rights.
- Not knowing the right words to use. Communication may be difficult for people with an intellectual disability and/or people may have received little personal development and sexuality education.
- Poor attitudes/responses of others to disclosures. People with intellectual disability are less likely to be believed if they attempt to report that an assault occurred against them (French, 2007).

### *5. RESPONDING TO DISCLOSURE: TIMEFRAMES*

The timing of when a sexual assault occurred will influence the victim/survivor's immediate needs and the most appropriate response. Some common terms used to describe when a sexual assault occurred:

- Crisis - the assault occurred in the immediate past (hours to days).

- Recent - the assault occurred within the past 12 months.
- Historical - the assault occurred more than 12 months ago.

Some physical effects of sexual violence such as injuries are often evident in the short-term. A crisis response may include supporting the victim/survivor to receive medical attention and securing evidence (on the person and/or at the scene of the assault). In the case of recent assault, physical injuries may or may not be healed, and other physical evidence is likely to have been destroyed. In the case of historical assault, physical injuries are likely to have healed and other physical evidence will have been destroyed. *Survivors of sexual violence may also experience long term health problems, which can be indicators of sexual trauma histories and which may require medical care.*

The emotional, psychological and behavioural effects of sexual violence change over time and are affected by the quality of support provided to victims/survivors. The long term effects of sexual violence are more likely to be debilitating when victims/survivors do not receive appropriate support to recover from the trauma they have experienced. *Many people with intellectual disability often do not receive any support following the experience of sexual violence.* The emotional, psychological and behavioural effects of sexual violence can also be influenced by whether the experience was a single event or part of an ongoing pattern of abuse (defined as "complex trauma") (Wall & Quadara, 2014). *For people with intellectual disability, experiences of abuse are often ongoing across their lives.*

## *6. GUIDING PRINCIPLES: CHOICE & CONTROL; SAFETY; DUTY OF CARE*

**Choice and Control**

Sexual violence is an abuse of power and control. As with all trauma, the abject loss of control and security experienced by the victim/survivor is a core feature of the harm done. As such, it is very important that responses to people who have experienced sexual violence allow the victim/survivor to be in control as much as is possible. For people with intellectual disability, this includes providing the information people need to make informed choices; giving explanations that people are able to understand (consider wording, time, pace, and reiterating important points); and support to consider options and potential consequences, and to make decisions.

Where control is taken from the victim/survivor, further or secondary trauma may be experienced. As such, any actions that remove personal choice and control from the victim/survivor must be taken as a last resort. Where possible this must be acknowledged and reason explained to the individual in a way they understand.

**Safety**

The safety of the victim/survivor is a core concern when responding to a disclosure of sexual violence. Responses to disclosure of sexual violence can include supporting the victim/survivor to plan how they can keep themselves safe in the future, and identify what they will do if they feel unsafe. It is important to note the limitations of safety plans when victims/survivors remain in ongoing contact with perpetrators. It is also important to note that safety planning places the onus of responsibility on the victim/survivor to keep themselves safe; and not on the perpetrator to cease abusive behaviours, or the society to detoxify environments and/or challenge myths and attitudes that make people with intellectual disability vulnerable to sexual violence and abuse.

Factors impacting the safety of people with intellectual disability that must be considered when developing safety plans include:

- ***Timeframes***: Is the person disclosing a crisis, recent, or historical sexual assault?
- ***Perpetrator***: Is the perpetrator known to the victim or a stranger? Will they have ongoing contact with the perpetrator (for example, family member, co-resident, service provider)?
- ***Personal capacity:*** For example, the person's age, level of impairment, degree of knowledge and understanding that the behaviour is assault.
- ***Social capacity***: For example, is the person reliant on the perpetrator for accommodation and care needs? Is the person vulnerable to engagement in abusive behaviours to meet financial and material needs, e.g. food, cigarettes; or emotional needs for relationships?

**Duty of Care**

It is important that our practices in responding to disclosure of sexual violence attend to the physical, emotional and psychological well-being of the client. *Choice & Control* and *Safety* are both important dimensions of *Duty of Care* to people with intellectual disability who experience sexual violence.

Duty of Care is both a legal and ethical concept. *Legally* it is the legal obligation which is imposed on an individual requiring adherence to a standard of reasonable care (for example, service providers and support workers) while performing any acts that could foreseeably harm others. It is the first element that must be established to proceed with an action in negligence. *Ethically,* duty of care may be considered a formalisation of the social contract, which are the implicit responsibilities held by each of us towards others within society (Department of Health, 2004).

In practice, there are often tensions between the principles of Choice & Control and Safety. Some strategies for managing these tensions are:

- Acknowledge these tensions are inevitable features of complex work.
- Understand your legal responsibility (Duty of Care) in the context of your organisational policies and professional ethics. Also reflect on your personal values. Are these consistent or are there tensions?
- Work collaboratively – discuss complex cases and decisions with your colleagues; seek supervision, peer mentoring and/or specialist advice; share information with your client (ask them what they want & let them know what you are doing).

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## Topic 6. Responding to Disclosure: Supportive Practices

### *1. FIRST RESPONSE*

Supportive practices for responding to a disclosure of sexual violence include:

i. Respond Calmly

- Treat the matter seriously and stay calm
- Find a private space to talk as soon as possible
- Listen, don't interrupt, don't distract their thoughts, and don't put words in their mouth.
- Don't panic and make it about your feelings - Do get support for yourself later!

ii. Comfort and Reassure

- Comfort and reassure the person, but be careful with physical contact as this could be triggering
- Tell the person that you believe them and reassure them they did the right thing telling
- Make sure the person feels listened to and allow them the time they need to tell you
- Allow the person to express their feelings freely and don't impose your own
- Don't blame the person for what has happened or do anything to give that impression

iii. Provide information

- Provide relevant and understandable information so the person can make choices
- Explain confidentiality, and limits to confidentiality. Tell the person where you have to report it further.
- Ask the person what they would like to happen next/now
- Tell the person what you are going to do next
- Don't make promises you can't keep. Don't agree to keep it a secret, or promise that it will never happen again.

iv. Understand your role

- Check and follow any agency guidelines
- Assess the person's safety (emotional and physical) and respond accordingly
- If possible, ensure any critical evidence is not destroyed
- Write a factual account of the conversation as soon as possible using the person's words
- *Remember, it's not your job to investigate*

- Don't pressure the person into telling you more than they want to.
- Don't ask probing, leading or intrusive questions. Use questions like "what happened?' "What do you mean?" "What happened next?"
- Do not correct or change the person's choice of words during the conversation or in later written documents
- Do not warn or confront the alleged abuser

## *2. ADDITIONAL RESPONSES*

You may be involved in a number of subsequent responses with a person with intellectual disability who has made a disclosure of sexual violence, including making a report to police; going to court; and obtaining financial assistance, advocacy support; and counselling. Each of these responses involves specialist knowledge and practice that are beyond the scope of this presentation. However, a brief overview each will be provided here to give you a basic familiarity with these responses, including some of the key issues that service providers and support workers should be aware of when supporting people with intellectual disability.

### i. **Reporting to Police**

*Making the decision to report*

- It must be the person's choice if they wish to report to police or not.
- It is their right to change their mind at any point until the perpetrator is arrested.
- Support the person to understand the investigation process and timeframes. Recent matters may be done relatively quickly. Historical matters may take several years to investigate and finish.

*Initial complaint*

- The person can make an initial complaint at local police station. It is best to ring the police station first. Let them know about the person's disability and make an appointment.
- The person can have a support person in the room, but the support person cannot be a witness. The person who first heard the complaint of sexual assault is a witness.
- The matter may be referred from there to the correct department, and a formal statement taken.
- The person can have a discussion with the police without making a complaint. They can make an official complaint, or a 'statement of no complaint' (report the assault but ask the police to take no action – online Alternative Reporting Options).

*Formal statement*

Ask for a video (93A) interview if possible. This is available to some people with an intellectual impairment, depending on level of disability. This can make the court process easier on the person and will get better quality of evidence.

*Barriers to reporting sexual violence to police*

- Fear of consequences. For example, fear that they may be in trouble if they report the crime
- Lack of knowledge around what constitutes a crime
- Dependency on abuser
- Physical barriers to accessing supports and services
- Poor literacy skills and difficulty completing required paperwork to make complaint (Literacy)
- Communication difficulties
- Loneliness. Resulting in putting up with exploitation from so-called carers/friends "Mate Crimes"
- People responding to people with disability based on negative attitudes, myths and stereotypes
- Low conviction rates
- Court process can be traumatic, many people choose not to go through it.

ii. **Going to Court**

*Court support – before court*

- Contact the Victim Liaison officer (if appointed) or police prosecutor or Department of Public Prosecutions and arrange meeting.
- Support person to inform the Victim Liaison Officer or prosecutor of their individual needs;
- Support person to tell prosecutor about the offence in their own words;
- Support person to prepare Victim Impact Statement;
- Advocate for person's needs during the court process (if this is possible within your role)
- Advocate for Special Witness Provisions
- If appropriate, offer a court report about the person, their disability, the crime and the impact of the crime
- Find out how court process unfolds, procedures, timelines, requirements, dress, etc that you will have to explain to victim and help them understand
- Visit court beforehand with the person (preferable) OR look on Department of Justice and Attorney General website at a virtual version
- Read through victim impact statement before going to court
- Plan some activities to do while waiting to be called
- DO NOT COACH victim on their statement or story

*Court support - in court*

- The victim needs a person to support them through the court process. Its long, arduous very confusing, and frightening. Help the person to know the small steps of the process.
- Support person can be family, friend, workers but they must not discuss the victim's story with them – you risk them being seen by the court as an unreliable witness.
- Person who has been charged with an offence may also need a support person

*Barriers to justice in the legal system*

(Grey, Forell & Clarke, S. 2009)

**Barriers to making it to trial**

- DPP making decision that victim will not withstand cross examination
- Assumptions by police or legal officers about the reliability of the victim as witness in court and misconceptions about people with cognitive impairments

**Barriers to receiving a fair trial**

- Special Witness provisions not always made available, complexity of court process, disallowing of communication aids in trial

**Difficulty with skills and tasks required during legal proceedings**

- Recall of events or correct sequencing (which is similar to how trauma affects most people)
- Abstract understanding
- Suggestibility
- Concentration - during long police interviews and court proceedings.
- Reliance on formal written processes (e.g. letter on when to appear in court)
- Poor organisational skills and memory may lead to failure to meet minor legal obligations (e.g. not paying a fine on time)
- Difficulty with alternative dispute resolution processes

**The complex and stressful nature of legal proceedings**

- Greater anxiety and stress for victim and family/carers.
- Ongoing trauma from the event and then subsequent trauma through the legal process
- Low conviction rates in sexual assault matters due to the need to prove guilt beyond reasonable doubt in court. There are no guarantees.

**Lack of appropriate support**

- Under-resourcing of specialist services

### iii. Financial Assistance

A range of financial assistance may be available to victims of crime (Queensland Government, 2015), including:

- Centrelink Crisis Payment (equivalent to 1 week's payment at usual rate) if ending domestic violence situation; Advance Payment (certain number in a 6 month period, can be up to $1100 for someone on DSP).
- Victims of Crime Queensland Financial Assistance. The Queensland Government provides financial assistance to victims of crime and may pay for or reimburse the costs of goods and services needed by a victim to recover from the physical and psychological effects of an act of violence. This financial assistance is designed to be available for victims to help reduce the stress and trauma involved in incidents of violent crime. Applications for financial assistance are made to Victims Assist Queensland and are decided by a government assessor.
- Medicare. If you are eligible for Medicare or have private health insurance, you may be able to claim back some of your medical or dental expenses resulting from the crime.
- Workers' compensation. If you have been injured as a result of violence at work, you may be entitled to workers' compensation. You should tell your employer as soon as possible about your injury and see a doctor to get a workers' compensation medical certificate.

### iv. Advocacy

People with intellectual disability often need advocacy support to ensure they access appropriate and available support and responses *in police and court processes* (for example, to have a support person present in interviews, to access Video 93A interview provisions); *in service systems* (for example, to relocate perpetrators to new accommodation where they are a co-resident with the victim/survivor in shared housing situations); and/or *to access available financial assistance* such as crisis and advanced payments).

### v. Counselling

There is a common belief that people with an ID are not affected by trauma and would not benefit from counselling. This is not true! However, counselling should be provided by a qualified, experienced and specialist counsellor.

It is important to note that people who experience traumatic events do not automatically require counselling, and many people recover from trauma with support from family, friends and community (however, we know people with intellectual disability may have a lack of supportive relationships). Counselling may be an appropriate response where people demonstrate signs of an intrusive trauma response that is interfering with their quality of life (for example, flashbacks of the event; avoiding reminders of the event; and experiencing ongoing fear, anxiety and/or emotional distress as a result of the event).

Where counselling support is indicated, service providers and support workers can take the following steps to assist a person with intellectual disability to go to counselling:

- Talk about what counselling is. For example, download the 'What is counselling?' infosheet from the WWILD website (www.wwild.org.au/what-is-counselling.html) and look through it with the person).
- Ask the person if they would like to try counselling. Let them know that counselling is about helping them feel better, and to be and feel safe. Let them know they do not have to talk about what happened to them (the trauma).
- As the person if they would like a support person to attend. The person can have someone in the counselling room if they wish, but this is their choice.
- If you attend counselling as a support person, do not speak for the person in counselling. Don't minimise or contradict the person's story. Remember, the problem is the problem, not the person!

How counselling works at WWILD:

- WWILD sees the person, not their disability.
- WWILD does not define the person by their sexual abuse or trauma.
- WWILD believes the client is the expert in their own life, not the counsellor.
- WWILD counsellors understand the need to take time to engage, build rapport, assess, identify and work on mutually agreed goals.
- WWILD counsellors adjust our communication style. We know that is our job to be understandable, rather than the client's job to understand.

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