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Queensland Mental Health Commission

Consultation paper:

Development of a whole-of-government Trauma Strategy for Queensland

Trauma and trauma informed approaches for people with disability

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What is this research about

People with disability are at increased risk of experiencing trauma across many facets of life. This document examines the current state of knowledge in relation to trauma, its impact and principles of trauma informed care and practice for people with disability. An environmental scan of the academic and grey literature was conducted to identify research and policy about trauma informed care and practice for people with disability and is complemented with clinical expertise. This knowledge was then used to inform recommendations for policy agenda and reform in this area.

The context for this research

Disability in Australia

Disability refers broadly to the limitations, restrictions, or impairments an individual experiences in relation to participation in everyday activities.[1] Whilst the medical model of disability ascribes these limitations to the individual's medical condition/s, the social model of disability is the preferred disability model in Australia and is the approach adopted in Article 1 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[2] This model views disability as a result of the interaction between an individual's impairment with the environment. For example, a lack of ramps to access a building is disabling, rather than the act of using a mobility aid. The AIHW reports approximately 1 in 6 people in Australia have a disability. Of these 4.4 million people, at least 3 in 5 need support for at least one daily life activity. Rates of disability are significantly higher in First Nations people, who have a nearly 3 times higher rate of disability in those aged under 65 years.[3]

Legislative Context and Safeguards to protect Queenslanders with Disability

The legislative context is important in this area, as it can and does shape relevant policy. Australia is a signatory to the CRPD. Article 16 of the CRPD refers to freedom from exploitation, violence and abuse and requires protection of persons with disability from all forms of exploitation and abuse. It contains detailed methods of achieving this protection, including education and support for people with disability and their support people, measures to promote recovery, and the institution of protective legislation and policies.[2] However, Australia's and subsequently Queensland's implementation of the CRPD varies.

Queensland has mandatory reporting requirements for suspected abuse in children but there is no similar requirement to report abuse of adults with impaired capacity. Rather, cases can be voluntarily reported to the Queensland Office of the Public Guardian, who have legislative powers to investigate.[4]

Restrictive practices, the restriction of the rights or freedom of movement of a person with disability (e.g., physically restraining an individual, prescribing a medication to control an individual's behaviour, keeping an individual secluded and not able to see other people), are also causes of trauma for individuals who may be subject to them due to the nature of their disability. There is Australian and Queensland legislation to provide safeguards and limits around the use of restrictive practices. The National Disability Insurance Scheme (NDIS) Act 2013 is

Queensland Government

federal legislation requiring NDIS providers to manage incidents, including those defined as reportable incidents such as serious injuries, unauthorised restrictive practices, or abuse.[5] It defines and regulates restrictive practices and requires reporting and oversight to reduce and eliminate their use. Restricted practices are further regulated by the Queensland's Guardianship and Administration Act 2000 and the Queensland Disability Services Act 2006, which also provides legislative definitions and powers for the Community Visitor Program, which provides a rights protection and abuse prevention service for Queenslanders with intellectual, cognitive, or psychiatric disability, who are in residential programs, care, or mental health facilities, who may be subject to abuse or neglect.[6]

NDIS and state-funded disability providers are required to ensure their staff have a Disability Worker Screening Card which includes checks and screening for criminal history, workplace misconduct, information about past employment, juvenile offences and any other relevant information that may determine whether a worker poses a risk to a person with disability.

Mainstream systems play a role in preventing, identifying, and supporting people with disability through trauma. However, it must be recognised the systems themselves can be traumatising. A clear example of this is within the criminal justice system. Initial contact with the justice system, either reporting to police or being investigated by police, can be a traumatising event for people with disability. It can be very challenging to provide sufficient evidence to uphold criminal charges, and the court process can be extremely stressful for people with disability, especially those with impaired communication or capacity. Research has found Australian police services have strategies for better interactions with people with disability, such as taking time to adjust communication and having community liaison officers present, but these strategies are applied irregularly and are impeded by negative attitudes.[7] In emergency situations, positive outcomes are further impeded by a lack of knowledge of police procedures around those providing information, and the difficulty of identifying communication needs during these situations. Beyond initial contact, even court-ordered actions taken for the perceived benefit of the individual can be traumatising, such as the removal of a person with impaired capacity from their usual care arrangements, establishing a need for trauma informed practice at all stages of justice system for people with disability.[8]

The key findings

Rates and effects of trauma in people with disability

The available data from the recent Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability reports over half of Australians with disability have experienced physical or sexual violence and between 57-73% of people with disability experiencing violence. People with disability are more likely to experience multiple incidents of violence and are more likely to know the perpetrator.[9] Due to a lack of appropriate support options, people with disability can experience the effects of trauma for between 3-20 years after the incident takes place.[8]

However, there is a lack of reliable reporting on the incidence and prevalence of trauma in Queenslanders and Australians with disability, including for First Nations people.[10] One of the reasons for this lack of national and state data is Australian Bureau of Statistics samples do not cover very remote areas, Aboriginal and Torres Strait Islander communities, or non-private dwellings, such as hospitals, institutions, hostels, or nursing homes where people with disability may reside.[11] Further, for a large number of individuals with disability, their disability impacts their ability to communicate with others and therefore report abuse or trauma. In these situations, individuals rely on those supporting them to detect whether trauma, abuse or neglect is occurring, and to act to report it. This dependence can be taken advantage of by perpetrators, resulting in underreporting of incidents and a greater risk of experiencing ongoing or multiple incidents of trauma.[9]

Trauma informed approaches for people with disability

There are some adaptions of trauma informed care for individuals with intellectual disability.[12,13] It is noted that many of these adaptions are common to what would be considered as reasonable adjustments for people with

disability. Efforts in the area to work within a trauma informed approach include creating a safe and stable environment by creating routines in appointments and treatments, providing support, and building the capacity of the individual's existing support system.[12] Trustworthiness can be implemented through adherence to ethical standards and respect for privacy, through understanding the experiences that brought people with disability to where they are now, both in their health and their general life circumstances, and by being aware of some of the common issues people with disability face.[12] Choice and empowerment can be incorporated by co-designing interventions, such as behavioural supports, and allowing individuals to make their own decisions regarding their treatment and care, and collaboration can be achieved by paying attention to the individual's interests, respecting their autonomy, and by being understanding of their circumstances, disability, and communication preferences.[12]

Implementing trauma informed approaches in day services for people with intellectual disability has demonstrated improved quality of life for individuals and increased staff satisfaction. One service promoted principles of trauma informed care by enabling choice in activities including refusal, providing social and group experiences, ongoing opportunities to explore existing and new interests, encouraged self-regulation, improved the physical environment to promote independence, and establishing strong rapport with staff.[14] The service recorded a significant reduction in incidents of behaviours of concern and reduced use of "as needed" or PRN medications.[14]

Further, co-designed, trauma-informed frameworks have also been developed for residential services[15] and health services[16] for people with intellectual disability. These models include trauma training for all staff, developing a language around trauma informed care, ongoing specialist support, evidence-based intervention delivery for clients impacted by trauma, integration of trauma informed care into client's positive behaviour support plans, person-centred care, and physical interventions. These strategies aim to improve quality of life for clients, improve working conditions for staff, and reduce the likelihood of placement break down.[15] Challenges to embedding trauma informed care into practice include high staff turnover, lack of collaboration between leadership and staff, lack of available training for staff and inflexible systems.[17,18]

While the research discussed is specific to people with intellectual disability, people with disability other forms of disability would also benefit from these approaches. For example, for members of the Deaf community and those hard of hearing, research has shown communication challenges has fallen on Deaf people to solve. Some of the primary problems Deaf people face in accessing healthcare have been a lack of awareness of the barriers, professionals unwillingness to adjust their communication, and a lack of interpreters.[19] Incorporating adjustments from a trauma informed lens is likely to improve outcomes for all people with disability.

Interventions to reduce impact of trauma on people with disability

There are gaps in the literature on reducing the impact of and supporting people with disability after trauma. For example, it is well accepted psychological therapies for post-traumatic stress disorder in people with intellectual disability require adaption but what specific adaptations are required have not been determined.[20] Another gap is the lack of standardised mental health assessment tools for people with disability with communication needs as current practice relies on caregiver reports as a method of assessment. It was further noted diagnostic overshadowing is a common complication in the assessment of stress disorders, particularly PTSD, in people with intellectual disability, and there are few tools available for people with moderate to severe intellectual disability.[21] Two recent UK studies investigated staff knowledge base of trauma and trauma informed care in specialist intellectual disability health professionals and support workers, managers and specialist practitioners working in community residential accommodation for people with intellectual disability. They found that staff had limited knowledge of trauma, how to implement evidence-based supports, and how to access specialist services, demonstrating that additional training and education is necessary.[12,22] One study using digital training to upskill support workers about trauma informed care which gave staff the language and space to think about how it applied to their work, but did not find statistically significant differences in test scores.[23] Further research has

shown organisations providing support services lack state or national level guidance for implementation of trauma informed policy and practice. For example, organisations may attempt to determine whether their clients have trauma histories, few would record this information, and include trauma informed care support strategies.[24]

Current approaches to addressing impacts of trauma for people with disability have been found to be highly variable, across selection and use of therapies, therapeutic models, and systemic processes regarding investigation of incidents.[25] These services need to be adapted to specific populations and specific disability types. For example, people with disability living in rural and remote areas have highlighted personal qualities, interpersonal connections, and access to social resources are key to resilience and recovery from trauma.[26] Among people who acquire disability through an accident (e.g., spinal cord injury, brain injury), the acquisition of the injury itself is often a traumatic event, creating a clear need for trauma informed care for these individuals. However, when undergoing mental health assessments and screening, evidence has shown the current processes lack sensitivity and attention to an individual's personal strength and resiliency.[27]

Interventions to prevent trauma in people with disability

Very little published research focussed on the prevention of trauma.[28] While all Australian jurisdictions have relevant regulations in place to report and prevent abuse of vulnerable people, no prevention strategies have been evaluated and reported on for their effectiveness. The value of some preventative strategies have been theorised, such as early sex and relationship education to increase awareness of sexual abuse, as young people often have delayed and limited sex and relationship education compared to their peers.[29]

What does this research mean for policymakers

People with disability are at increased risk of trauma, including in the health, criminal justice, and other systems, are more likely to have trauma undetected, and may require specific adjustments and adaptation of trauma informed approaches used in the general population. There is a lack of acknowledgement and reporting of trauma in people with disability. There is a lack of evidence-based treatments to reduce the impact of trauma, especially in those with cognitive disability. Existing legislation provides some safeguarding but could be strengthened.

Options for reform

Reforms efforts must be conducted in line with the recommendations and work arising from the Disability Royal Commission. Reforms must be co-designed with people with disability from a diverse range of experiences including First Nations people, culturally and linguistically diverse communities, and rural and remote areas.

Prevention of trauma for people with disability

1. Legislation to mandate mainstream services make reasonable adjustments to improve access for people with disability.
2. Fund increased provision of safety programs such as sexual education for people with disability.
3. Increase funding of disability advocacy services to include dedicated individual advocacy services for people with disability, including specific services for criminal justice and correctional systems.
4. Develop a Trauma Prevention Plan, which aligns with the Queensland Disability Plan and which integrates Indigenous knowledges to address the specific experiences of First Nations Australians with disability.
5. Fund prevention and early interventions for people with disability at risk of experiencing trauma, particularly those in contact with the criminal justice system, by for example expanding co-responder programs.

Improve identification of trauma in people with disability

1. Institute data collection across mainstream services to identify the number of people with disability and identify those impacted by trauma, in a manner informed by people with disability.

2. Develop a system-wide register (subject to privacy considerations) for relevant government services to enhance communication between sectors for people with disability to improve service provision (e.g., health, NDIS).
3. Support a transition away from caregiver reports of traumatic events where possible by providing translative services (e.g., Auslan) and converting resources and tools into appropriate formats (e.g., Easy Read, braille).
4. Legislate the mandatory reporting of suspected abuse of adults with impaired capacity.
5. Increase resourcing of the Community Visitor Program and the Office of the Public Guardian to offer advice and support to those considering reporting suspected abuse and investigate abuse.

Reduce impact of trauma for people with disability

1. Develop and implement guidelines for services to formulate and deliver trauma informed, tailored services to people with disability (e.g., emergency services, health, education, correctional services).
2. Co-design disability awareness and trauma informed care in disability training for mainstream systems.
3. Fund trauma-specific therapeutic services for people with disability.

Fund targeted research to fill gaps in evidence base

1. Understand the different experiences of people with disability, including Aboriginal and Torres Strait Islanders, people in rural and remote areas, and those with complex communication requirements.
2. Co-design, develop and evaluate
   a. disability-specific trauma screening tools suitable for use in routine screening.
   b. mental health and developmental assessment tools that consider trauma as a separate or co-occurring phenomenon in people with disability.
   c. trauma informed treatments and therapies adapted to the needs of people with disability.

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