

# FINAL REPORT

Advocacy, support and  
therapeutic treatment services



**Royal Commission**  
into Institutional Responses  
to Child Sexual Abuse

VOLUME 9

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# FINAL REPORT

Volume 9

Advocacy, support and  
therapeutic treatment services

## Content warning

This volume contains information about child sexual abuse that may be distressing. We also wish to advise Aboriginal and Torres Strait Islander readers that information in this volume may have been provided by or refer to Aboriginal and Torres Strait Islander people who have died.

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# Preface

## The Royal Commission

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The Letters Patent provided to the Royal Commission required that it ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’. In carrying out this task, the Royal Commission was directed to focus on systemic issues, be informed by an understanding of individual cases, and make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs. The Royal Commission did this by conducting public hearings, private sessions and a policy and research program.

## Public hearings

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A Royal Commission commonly does its work through public hearings. We were aware that sexual abuse of children has occurred in many institutions, all of which could be investigated in a public hearing. However, if the Royal Commission was to attempt that task, a great many resources would need to be applied over an indeterminate, but lengthy, period of time. For this reason the Commissioners accepted criteria by which Senior Counsel Assisting would identify appropriate matters for a public hearing and bring them forward as individual ‘case studies’.

The decision to conduct a case study was informed by whether or not the hearing would advance an understanding of systemic issues and provide an opportunity to learn from previous mistakes so that any findings and recommendations for future change the Royal Commission made would have a secure foundation. In some cases the relevance of the lessons to be learned will be confined to the institution the subject of the hearing. In other cases they will have relevance to many similar institutions in different parts of Australia.

Public hearings were also held to assist in understanding the extent of abuse that may have occurred in particular institutions or types of institutions. This enabled the Royal Commission to understand the ways in which various institutions were managed and how they responded to allegations of child sexual abuse. Where our investigations identified a significant concentration of abuse in one institution, the matter could be brought forward to a public hearing.

Public hearings were also held to tell the stories of some individuals, which assisted in a public understanding of the nature of sexual abuse, the circumstances in which it may occur and, most importantly, the devastating impact that it can have on people’s lives. Public hearings were open to the media and the public, and were live streamed on the Royal Commission’s website.

The Commissioners' findings from each hearing were generally set out in a case study report. Each report was submitted to the Governor-General and the governors and administrators of each state and territory and, where appropriate, tabled in the Australian Parliament and made publicly available. The Commissioners recommended some case study reports not be tabled at the time because of current or prospective criminal proceedings.

We also conducted some private hearings, which aided the Royal Commission's investigative processes.

## Private sessions

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When the Royal Commission was appointed, it was apparent to the Australian Government that many people (possibly thousands) would wish to tell us about their personal history of sexual abuse as a child in an institutional setting. As a result, the Australian Parliament amended the *Royal Commissions Act 1902* (Cth) to create a process called a 'private session'.

Each private session was conducted by one or two Commissioners and was an opportunity for a person to tell their story of abuse in a protected and supportive environment. Many accounts from these sessions are told in a de-identified form in this Final Report.

Written accounts allowed individuals who did not attend private sessions to share their experiences with Commissioners. The experiences of survivors described to us in written accounts have informed this Final Report in the same manner as those shared with us in private sessions.

We also decided to publish, with their consent, as many individual survivors' experiences as possible, as de-identified narratives drawn from private sessions and written accounts. These narratives are presented as accounts of events as told by survivors of child sexual abuse in institutions. We hope that by sharing them with the public they will contribute to a better understanding of the profound impact of child sexual abuse and may help to make our institutions as safe as possible for children in the future. The narratives are available as an online appendix to Volume 5, *Private sessions*.

We recognise that the information gathered in private sessions and from written accounts captures the accounts of survivors of child sexual abuse who were able to share their experiences in these ways. We do not know how well the experiences of these survivors reflect those of other victims and survivors of child sexual abuse who could not or did not attend a private session or provide a written account.



## Policy and research

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The Royal Commission had an extensive policy and research program that drew upon the findings made in public hearings and upon survivors' private sessions and written accounts, as well as generating new research evidence.

The Royal Commission used issues papers, roundtables and consultation papers to consult with government and non-government representatives, survivors, institutions, regulators, policy and other experts, academics, and survivor advocacy and support groups. The broader community had an opportunity to contribute to our consideration of systemic issues and our responses through our public consultation processes.

## Community engagement

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The community engagement component of the Royal Commission's inquiry ensured that people in all parts of Australia were offered the opportunity to articulate their experiences and views. It raised awareness of our work and allowed a broad range of people to engage with us.

We involved the general community in our work in several ways. We held public forums and private meetings with survivor groups, institutions, community organisations and service providers. We met with children and young people, people with disability and their advocates, and people from culturally and linguistically diverse communities. We also engaged with Aboriginal and Torres Strait Islander peoples in many parts of Australia, and with regional and remote communities.

## Diversity and vulnerability

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We heard from a wide range of people throughout the inquiry. The victims and survivors who came forward were from diverse backgrounds and had many different experiences. Factors such as gender, age, education, culture, sexuality or disability had affected their vulnerability and the institutional responses to the abuse. Certain types of institutional cultures and settings created heightened risks, and some children's lives brought them into contact with these institutions more than others.

While not inevitably more vulnerable to child sexual abuse, we heard that Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds were more likely to encounter circumstances that increased their risk of abuse in institutions, reduced their ability to disclose or report abuse and, if they did disclose or report, reduced their chances of receiving an adequate response.

We examined key concerns related to disability, cultural diversity and the unique context of Aboriginal and Torres Strait Islander experience, as part of our broader effort to understand what informs best practice institutional responses. We included discussion about these and other issues of heightened vulnerability in every volume. Volume 5, *Private sessions* outlines what we heard in private sessions from these specific populations.

## Our interim and other reports

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On 30 June 2014, in line with our Terms of Reference, we submitted a two-volume interim report of the results of the inquiry. Volume 1 described the work we had done, the issues we were examining and the work we still needed to do. Volume 2 contained a representative sample of 150 de-identified personal stories from people who had shared their experiences at a private session.

Early in the inquiry it became apparent that some issues should be reported on before the inquiry was complete to give survivors and institutions more certainty on these issues and enable governments and institutions to implement our recommendations as soon as possible. Consequently, we submitted the following reports:

- *Working With Children Checks* (August 2015)
- *Redress and civil litigation* (September 2015)
- *Criminal justice* (August 2017)

## Definition of terms

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The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are set out in Chapter 1, 'Introduction' and in the Final Report Glossary, in Volume 1, *Our inquiry*.

## Naming conventions

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To protect the identity of victims and survivors and their supporters who participated in private sessions, pseudonyms are used. These pseudonyms are indicated by the use of single inverted commas, for example, ‘Roy’.

As in our case study reports, the identities of some witnesses before public hearings and other persons referred to in the proceedings are protected through the use of assigned initials, for example, BZW.

## Structure of the Final Report

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The Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse consists of 17 volumes and an executive summary. To meet the needs of readers with specific interests, each volume can be read in isolation. The volumes contain cross references to enable readers to understand individual volumes in the context of the whole report.

In the Final Report:

The **Executive Summary** summarises the entire report and provides a full list of recommendations.

**Volume 1, *Our inquiry*** introduces the Final Report, describing the establishment, scope and operations of the Royal Commission.

**Volume 2, *Nature and cause*** details the nature and cause of child sexual abuse in institutional contexts. It also describes what is known about the extent of child sexual abuse and the limitations of existing studies. The volume discusses factors that affect the risk of child sexual abuse in institutions and the legal and political changes that have influenced how children have interacted with institutions over time.

**Volume 3, *Impacts*** details the impacts of child sexual abuse in institutional contexts. The volume discusses how impacts can extend beyond survivors, to family members, friends, and whole communities. The volume also outlines the impacts of institutional responses to child sexual abuse.

**Volume 4, *Identifying and disclosing child sexual abuse*** describes what we have learned about survivors’ experiences of disclosing child sexual abuse and about the factors that affect a victim’s decision whether to disclose, when to disclose and who to tell.

**Volume 5, *Private sessions*** provides an analysis of survivors' experiences of child sexual abuse as told to Commissioners during private sessions, structured around four key themes: experiences of abuse; circumstances at the time of the abuse; experiences of disclosure; and impact on wellbeing. It also describes the private sessions model, including how we adapted it to meet the needs of diverse and vulnerable groups.

**Volume 6, *Making institutions child safe*** looks at the role community prevention could play in making communities and institutions child safe, the child safe standards that will make institutions safer for children, and how regulatory oversight and practice could be improved to facilitate the implementation of these standards in institutions. It also examines how to prevent and respond to online sexual abuse in institutions in order to create child safe online environments.

**Volume 7, *Improving institutional responding and reporting*** examines the reporting of child sexual abuse to external government authorities by institutions and their staff and volunteers, and how institutions have responded to complaints of child sexual abuse. It outlines guidance for how institutions should handle complaints, and the need for independent oversight of complaint handling by institutions.

**Volume 8, *Recordkeeping and information sharing*** examines records and recordkeeping by institutions that care for or provide services to children; and information sharing between institutions with responsibilities for children's safety and wellbeing and between those institutions and relevant professionals. It makes recommendations to improve records and recordkeeping practices within institutions and information sharing between key agencies and institutions.

**Volume 9, *Advocacy, support and therapeutic treatment services*** examines what we learned about the advocacy and support and therapeutic treatment service needs of victims and survivors of child sexual abuse in institutional contexts, and outlines recommendations for improving service systems to better respond to those needs and assist survivors towards recovery.

**Volume 10, *Children with harmful sexual behaviours*** examines what we learned about institutional responses to children with harmful sexual behaviours. It discusses the nature and extent of these behaviours and the factors that may contribute to children sexually abusing other children. The volume then outlines how governments and institutions should improve their responses and makes recommendations about improving prevention and increasing the range of interventions available for children with harmful sexual behaviours.

**Volume 11, *Historical residential institutions*** examines what we learned about survivors' experiences of, and institutional responses to, child sexual abuse in residential institutions such as children's homes, missions, reformatories and hospitals during the period spanning post-World War II to 1990.

**Volume 12, *Contemporary out-of-home care*** examines what we learned about institutional responses to child sexual abuse in contemporary out-of-home care. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in out-of-home care and, where it does occur, to help ensure effective responses.

**Volume 13, *Schools*** examines what we learned about institutional responses to child sexual abuse in schools. The volume examines the nature and adequacy of institutional responses and draws out the contributing factors to child sexual abuse in schools. It makes recommendations to prevent child sexual abuse from occurring in schools and, where it does occur, to help ensure effective responses to that abuse.

**Volume 14, *Sport, recreation, arts, culture, community and hobby groups*** examines what we learned about institutional responses to child sexual abuse in sport and recreation contexts. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in sport and recreation and, where it does occur, to help ensure effective responses.

**Volume 15, *Contemporary detention environments*** examines what we learned about institutional responses to child sexual abuse in contemporary detention environments, focusing on youth detention and immigration detention. It recognises that children are generally safer in community settings than in closed detention. It also makes recommendations to prevent child sexual abuse from occurring in detention environments and, where it does occur, to help ensure effective responses.

**Volume 16, *Religious institutions*** examines what we learned about institutional responses to child sexual abuse in religious institutions. The volume discusses the nature and extent of child sexual abuse in religious institutions, the impacts of this abuse, and survivors' experiences of disclosing it. The volume examines the nature and adequacy of institutional responses to child sexual abuse in religious institutions, and draws out common factors contributing to the abuse and common failings in institutional responses. It makes recommendations to prevent child sexual abuse from occurring in religious institutions and, where it does occur, to help ensure effective responses.

**Volume 17, *Beyond the Royal Commission*** describes the impacts and legacy of the Royal Commission and discusses monitoring and reporting on the implementation of our recommendations.

Unless otherwise indicated, this Final Report is based on laws, policies and information current as at 30 June 2017. Private sessions quantitative information is current as at 31 May 2017.



# Summary

This volume examines the advocacy and support and therapeutic treatment service needs of victims and survivors of child sexual abuse in institutions and makes recommendations for how best to meet these needs. Through public hearings, private sessions, research and consultation processes, we have gained an understanding of the diverse needs of children and adults who experienced childhood sexual abuse in institutions and the strengths and weaknesses of service systems in responding to those needs.

Throughout our inquiry, we often heard that institutional child sexual abuse has occurred alongside child sexual abuse in familial or community contexts. Many survivors told us the impacts of the sexual abuse they experienced in institutions were compounded by sexual abuse they experienced elsewhere. Our work has made us aware of the needs of victims and survivors of child sexual abuse in non-institutional settings and we identified gaps in services that affect all groups of survivors.

We recognise that the services and systems responses we have considered will in many circumstances be applicable to all survivors of child sexual abuse, no matter what the context of the abuse. While we have identified essential responses for survivors of institutional child sexual abuse, it is unrealistic in some situations for advocacy and support and therapeutic treatment services to only be provided to institutional survivors. A number of our recommendations are therefore applicable to service systems for all victims and survivors of child sexual abuse.

## The need for advocacy and support and therapeutic treatment services

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The trauma of institutional child sexual abuse can have profound, long-lasting and cumulative impacts on victims and survivors. Many survivors face a complex set of challenges throughout their lives. At various times, depending on the circumstances, victims and survivors seek support from a range of mainstream and specialist services to help manage the detrimental impacts of abuse on their mental health. They may also need support for legal, education, housing, health, employment and financial issues, and for assistance with reporting abuse. The services used by victims and survivors span several sectors and can be difficult to navigate. The need for support often extends to secondary victims, such as family members, carers and friends and others in the institution where the abuse occurred.

Advocacy and support and therapeutic treatment services are interdependent, assisting victims and survivors by addressing their practical, emotional and therapeutic needs. Advocacy and support can connect people to therapeutic treatment and can also *be* therapeutic. A strong advocacy sector can ensure responsive support services, effective and appropriate therapeutic treatments, and continuous improvement.

Survivors' needs are interconnected and change over time. The type of advocacy and support and therapeutic treatment a child, young person, adult or older person who has experienced childhood sexual abuse may need and find helpful can vary, depending on the person's life stage.

## The shape of the service system

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There is no single entry point to the service system for child and adult victims and survivors or secondary victims of institutional child sexual abuse. The types of services that victims and survivors access to address their advocacy and support and therapeutic treatment needs include:

- mainstream services, including mental health services, alcohol and other drugs services, community health services, general practitioners (GPs) and private practitioners such as psychologists
- community support services, including services for specific populations, such as Aboriginal Community Controlled Health Services, multicultural organisations or peer-based survivor support groups
- specialist services, such as child and adult sexual assault services.

Advocacy and support and therapeutic treatment are also provided through other system responses to reported cases of child sexual abuse – for example, redress schemes or criminal justice procedures. They are also provided in various institutions with which child and adult victims and survivors engage, for example, schools, out-of-home care and detention settings.

Currently, service systems across Australia do not have the capacity to meet victims' and survivors' needs. Inadequacies are most apparent when a victim or survivor is experiencing multiple and complex impacts from the trauma of child sexual abuse, particularly for those deemed as not fitting within the remit of a single service. In many cases, one individual will be in multiple systems, moving in and out of services over many years.



## Barriers to help-seeking and effective service responses

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Throughout our inquiry, we heard a strong message about the barriers victims and survivors face when seeking assistance from services. Many survivors said they faced stigmatising community and professional attitudes about child sexual abuse. We were told that information was difficult to find and that services were often prohibitively expensive. We also heard about the range of systemic and structural barriers that created difficulties for survivors. This included the fragmentation of the various service systems they access, the limited capacity of services to collaborate with one another, the lack of relevant knowledge among mainstream service providers, the scarcity of resources in specialist sectors and a lack of cultural competence and disability awareness. We heard that the standard of service provision is inconsistent within and across jurisdictions. We were told about particular gaps in services, including for children and young people who have experienced sexual abuse, male survivors, survivors entering aged care settings, and survivors in and transitioning out of prisons or other detention settings. We heard survivors living in regional and remote communities face additional barriers to accessing services and have less choice of service providers.

Inadequate service responses can re-traumatise survivors of child sexual abuse. Poor therapeutic treatment can leave a victim with chronic symptoms that follow them into adulthood. Ineffective treatment may cause victims to lose hope and disengage from treatment altogether.

For services and professionals, failing to improve collaboration can mean knowledge and skills remain compartmentalised. A workforce without the right skills, knowledge and support mechanisms not only diminishes the quality of service provision, but also puts at risk the wellbeing of professionals working in a challenging field.

Low-quality services also diminish the effectiveness of government expenditure. The lifetime impacts of child sexual abuse on victims, their families and communities are broad-ranging and entail significant economic costs to individuals and governments in healthcare expenditure, lost earnings and tax revenue, increased costs associated with income support and child protection, and increased crime. Supporting victims and survivors to heal will interrupt cycles of trauma and enhance their quality of life and their ability to lead productive lives.

## Improving service systems for victims and survivors

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Demand for services is likely to continue from victims and survivors of child sexual abuse in institutions who engaged with the Royal Commission during our inquiry. They may need continued support immediately following the conclusion of our inquiry, or other support in the future. As knowledge increases on the extent of child sexual abuse and as social stigma surrounding sexual abuse diminishes, demand may also arise from victims and survivors who have not engaged with the Royal Commission, but want to reach out for assistance.

Our *Redress and civil litigation* report recommended that the Australian Government establish a national redress scheme for survivors. In relation to support and therapeutic treatment, the report recommended that a redress scheme should:

- fund support services and community legal centres to assist applicants to apply for redress (Recommendation 52)
- offer and fund counselling for applicants, and their family members if reasonably required, during the redress process (Recommendations 66–68)
- on an ongoing basis, provide support for counselling and psychological care as needed throughout a survivor's life, for survivors assessed as eligible for redress (Recommendations 2, 9–14).

In response, the Australian Government has announced a national redress scheme that will include psychological counselling as an element of redress.<sup>1</sup> The Australian Government has also announced that:<sup>2</sup>

- there will be a dedicated telephone helpline and website to provide information to survivors and their families about the redress scheme
- survivors will be connected with legal and community support services that are currently provided through the Royal Commission and which will continue to be funded to support the redress scheme.

The extent to which governments other than the Australian Government and non-government institutions opt in to the national redress scheme is not yet clear. However, we are encouraged by the Australian Government's leadership of the redress scheme and its commitment to provide ongoing counselling and psychological care as an element of redress and fund services to assist survivors to apply for redress.

This volume addresses the service system more broadly than we considered in relation to redress. Some survivors will not seek redress, and others may not be eligible. Further, the service system includes service responses beyond counselling and psychological care.

Our recommendations in this volume are intended to guide funders and providers of advocacy and support and therapeutic treatment so that services adequately meet the needs of victims and survivors outside of redress. We note that the material in this volume will also be valuable to those involved in designing and implementing relevant services in relation to redress.

Our recommendations in this volume aim to achieve service systems that:

- have the necessary components to respond adequately to victims' and survivors' support needs
- understand the ways child sexual abuse and institutional responses to it can affect an individual, their families and communities, and the way trauma can influence service needs
- provide a holistic response to victims and survivors as part of a cohesive systems approach
- support services and staff to sustainably work with victims and survivors safely, efficiently and effectively
- are underpinned by the principles of trauma-informed practice and an understanding of institutional child sexual abuse; and by the principles of collaboration, availability, accessibility, acceptability and high quality.

We consider that to meet the needs of children and adults who experienced childhood sexual abuse in institutions, the service system should include:

- a dedicated system of community-based support services for victims and survivors. This system should provide advocacy and support, including counselling, case management and brokerage assistance to coordinate and link to other services; it should facilitate peer-led support; and it should include Aboriginal and Torres Strait Islander healing approaches and disability-specific services
- a national service to assist victims and survivors to understand legal options and to navigate the legal system
- a national telephone helpline and website that are central, visible points through which victims, survivors, professionals and the broader community can get information and assistance to navigate the service system
- enhanced capacity of sexual assault services to provide specialist advocacy and support and therapeutic treatment for victims and survivors, and address service gaps
- mainstream services capable of responding effectively to survivors with complex trauma.

## National leadership to reduce stigma, promote help-seeking and support good practice

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The impacts of child sexual abuse are compounded by secrecy and silence. Many survivors told us in private sessions the existence of the Royal Commission encouraged them to speak out and seek support. For some, the stigma associated with child sexual abuse was lifted by the work of the Royal Commission. Witnesses in our public hearings spoke of the increased awareness and positive progress made in response to our inquiry. The conclusion of the Royal Commission presents a potential risk that this positive momentum will stall. For this reason, we recommend governments task and fund an organisation to reduce stigma, maintain national attention on the impacts of child sexual abuse and build and translate evidence to inform the ongoing development of good practice for advocacy and support and therapeutic treatment services.

We know that to have the best opportunity to heal, survivors must feel safe to disclose and receive support that is non-stigmatising, appropriate to their needs, and effective. Practitioners should have access to the best available evidence and programs should be evaluated to continuously drive improvement. During the Royal Commission, we gathered knowledge and contributed new evidence to support best practice. However, gaps in research on the experiences and outcomes of survivors of institutional child sexual abuse still exist. Evidence on the effectiveness of therapeutic treatment is also limited. In particular, research to better understand therapeutic treatment approaches for a range of specific groups is needed. Currently, the coordination and translation of knowledge about trauma-informed approaches into practice is ad hoc, impacting workforce skills and exacerbating shortages in expertise.

While a number of organisations currently advocate for survivors and support awareness raising in related areas of trauma and child maltreatment, there is no national focus specifically on child sexual abuse. We are of the view that to sustain the current momentum for change, ongoing national leadership is necessary to reduce stigma, promote help-seeking and support good practice.

To this end, we recommend the creation of a national centre for children and adults who experienced sexual abuse in childhood to:

- undertake strategic awareness raising and stigma reduction activities to foster help-seeking behaviours
- provide national leadership in knowledge translation by promoting best practice in education and training and by promoting nationally consistent practice guidelines
- promote strategically important research and evaluation to address gaps in knowledge.

# Recommendations

The following is a list of the recommendations made in this volume.

## Dedicated community support services for victims and survivors (Chapter 5)

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### **Recommendation 9.1**

The Australian Government and state and territory governments should fund dedicated community support services for victims and survivors in each jurisdiction, to provide an integrated model of advocacy and support and counselling to children and adults who experienced childhood sexual abuse in institutional contexts.

Funding and related agreements should require and enable these services to:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. use case management and brokerage to coordinate and meet service needs
- d. support and supervise peer-led support models.

### **Recommendation 9.2**

The Australian Government and state and territory governments should fund Aboriginal and Torres Strait Islander healing approaches as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse. These approaches should be evaluated in accordance with culturally appropriate methodologies, to contribute to evidence of best practice.

### **Recommendation 9.3**

The Australian Government and state and territory governments should fund support services for people with disability who have experienced sexual abuse in childhood as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse.

## National service to navigate legal processes (Chapter 5)

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### **Recommendation 9.4**

The Australian Government should establish and fund a legal advice and referral service for victims and survivors of institutional child sexual abuse. The service should provide advice about accessing, amending and annotating records from institutions, and options for initiating police, civil litigation or redress processes as required. Support should include advice, referrals to other legal services for representation and general assistance for people to navigate the legal service system.

Funding and related agreements should require and enable these services to be:

- a. trauma-informed and have an understanding of institutional child sexual abuse
- b. collaborative, available, accessible, acceptable and high quality.

## National telephone helpline and website (Chapter 5)

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### **Recommendation 9.5**

The Australian Government should fund a national website and helpline as a gateway to accessible advice and information on childhood sexual abuse. This should provide information for victims and survivors, particularly victims and survivors of institutional child sexual abuse, the general public and practitioners about supporting children and adults who have experienced sexual abuse in childhood and available services. The gateway may be operated by an existing service with appropriate experience and should:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. provide telephone and online information and initial support for victims and survivors, including independent legal information and information about reporting to police
- d. provide assisted referrals to advocacy and support and therapeutic treatment services.

## Enhancing the capacity of specialist sexual assault services (Chapter 5)

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### **Recommendation 9.6**

The Australian Government and state and territory governments should address existing specialist sexual assault service gaps by increasing funding for adult and child sexual assault services in each jurisdiction, to provide advocacy and support and specialist therapeutic treatment for victims and survivors, particularly victims and survivors of institutional child sexual abuse. Funding agreements should require and enable services to:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. use collaborative community development approaches
- d. provide staff with supervision and professional development.

### **Recommendation 9.7**

Primary Health Networks, within their role to commission joined up local primary care services, should support sexual assault services to work collaboratively with key services such as disability-specific services, Aboriginal and Torres Strait Islander services, culturally and linguistically diverse services, youth justice, aged care and child and youth services to better meet the needs of victims and survivors.

## Responsive mainstream services (Chapter 5)

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### **Recommendation 9.8**

The Australian Government and state and territory government agencies responsible for the delivery of human services should ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches.

## National leadership to reduce stigma, promote help-seeking and support good practice (Chapter 6)

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### **Recommendation 9.9**

The Australian Government, in conjunction with state and territory governments, should establish and fund a national centre to raise awareness and understanding of the impacts of child sexual abuse, support help-seeking and guide best practice advocacy and support and therapeutic treatment. The national centre's functions should be to:

- a. raise community awareness and promote destigmatising messages about the impacts of child sexual abuse
- b. increase practitioners' knowledge and competence in responding to child and adult victims and survivors by translating knowledge about the impacts of child sexual abuse and the evidence on effective responses into practice and policy. This should include activities to:
  - i. identify, translate and promote research in easily available and accessible formats for advocacy and support and therapeutic treatment practitioners
  - ii. produce national training materials and best practice clinical resources
  - iii. partner with training organisations to conduct training and workforce development programs
  - iv. influence national tertiary curricula to incorporate child sexual abuse and trauma-informed care
  - v. inform government policy making
- c. lead the development of better service models and interventions through coordinating a national research agenda and conducting high-quality program evaluation.

The national centre should partner with survivors in all its work, valuing their knowledge and experience.

# Endnotes

- 1 Senator G Brandis, Attorney-General & C Porter MP, Minister for Social Services, *Commonwealth redress scheme for survivors of institutional child sexual abuse*, media release, Parliament House, Canberra, 4 November 2016.
- 2 C Porter MP, Minister for Social Services & Senator G Brandis, Attorney General, *Commonwealth redress scheme for survivors of institutional child sexual abuse*, media release, Parliament House, Canberra, 9 May 2017.



# 1 Introduction

## 1.1 Overview

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This volume examines what is needed to improve the response of advocacy and support and therapeutic treatment service systems to children and adults who experienced child sexual abuse in institutions. It outlines the Royal Commission's conclusions and recommendations for improving services to meet the needs of victims and survivors outside of redress.

In our *Redress and civil litigation* report, we stated we would undertake separately to 'examine the adequacy of existing support services in meeting the needs of survivors and others affected by institutional child sexual abuse, including survivors' family members and broader communities'.<sup>1</sup> We said we would consider whether any recommendations should be made on increasing or otherwise changing existing services, and we acknowledged the importance of these services. We noted further work outside of redress is important because:<sup>2</sup>

- 'it should be acknowledged that a redress scheme is not necessarily the best, or even an appropriate mechanism for meeting all the various needs that survivors may have
- existing support services are highly valued by many survivors
- some elements of redress (particularly counselling and psychological care) overlap with the services that some existing support services and general public programs provide
- nothing that we recommend in relation to redress and civil litigation is intended to reduce resources for, or divert effort from existing support services'.

When survivors of child sexual abuse present to services outside of the redress scheme, they should be met with a skilled, well-informed response. However, we have heard throughout our inquiry of shortcomings in the mainstream service sector. We have heard that when survivors engage with mainstream services such as mental health, drug and alcohol, health or generalist counselling programs, they may not receive a response that considers their childhood trauma. They may not disclose their experience of institutional child sexual abuse or, if they do disclose, practitioners may not address complex trauma as a potential underlying issue.

This volume recommends service system reform to support victims and survivors to heal and recover, interrupt cycles of cumulating trauma and, where the need arises, enhance the capacity of victims and survivors to lead productive, fulfilling lives.

The conclusions in this volume were developed through detailed consideration of information gathered in our case studies, private sessions and written accounts. In particular, *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts* included expert discussion about key elements and models of responsive advocacy and support and therapeutic treatment and how service systems could better respond to victims and survivors.

Our conclusions were also informed by research we commissioned, particularly: *Family relationships and the disclosure of institutional child sexual abuse*;<sup>3</sup> *Pathways to support services for victim/survivors of child sexual abuse and their families*;<sup>4</sup> and *Capturing practice knowledge from the Royal Commission support model*.<sup>5</sup> In addition, our conclusions draw on reviews we commissioned of existing evidence: *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*;<sup>6</sup> *Rapid evidence review on the availability, modality and effectiveness of psychosocial support services for child and adult victims and survivors of child sexual abuse*;<sup>7</sup> *Service and support needs of specific population groups that have experienced child sexual abuse*;<sup>8</sup> and *Principles of trauma-informed approaches to child sexual abuse: A discussion paper*.<sup>9</sup> We also considered other relevant literature, reports and policy papers.

We conducted consultations focused on advocacy and support and therapeutic treatment services to better understand the needs of victims and survivors and develop recommendations. We released *Issues paper 10: Advocacy and support and therapeutic treatment services* in October 2015 and received 179 submissions to it. We also met with several organisations working with and for victims and survivors.

We presented our preliminary policy positions at two private roundtables, on 31 May 2016 and 1 June 2016. The roundtables brought together a diverse range of stakeholders including 23 service providers that deliver advocacy and support and therapeutic treatment, some of which were survivor-led. The roundtables also included two academics and 16 representatives from various Australian Government and state and territory government departments covering health, human and social services, child protection and justice portfolios. The views from these roundtables informed our conclusions and final deliberations on how to improve service systems so that they promote healing and recovery for children and adults who experienced child sexual abuse in institutions.

## 1.2 Terms of Reference

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This volume particularly addresses paragraph (d) of our Terms of Reference, which required the Royal Commission to inquire into what institutions and governments should do to mitigate the impact of child sexual abuse in institutional contexts. Support services such as victim and survivor advocacy and support and therapeutic treatment are an important part of this. In case studies and private sessions we heard how these services helped individuals, their families and communities to overcome adversity and achieve positive wellbeing.

## 1.3 Links with other volumes

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Volume 3, *Impacts* provides a detailed discussion of our knowledge about the impacts of child sexual abuse and institutional responses, including the impacts on secondary victims. It gives context to the issues examined in this volume and is important supplementary material.

Volume 4, *Identifying and disclosing child sexual abuse* discusses in detail the disclosure of institutional child sexual abuse. This is important for understanding the dynamics of disclosure, and developing safe and supportive service responses.

The discussion of therapeutic treatment in this volume is specific to child and adult victims and survivors of child sexual abuse. Volume 10, *Children with harmful sexual behaviours* contains a separate discussion of therapeutic treatment for children with harmful sexual behaviours.

Volumes 11–16 address in more detail the needs of survivors in specific institutional contexts. For example, Volume 12, *Contemporary out-of-home care* considers the role of therapeutic care for children who experienced child sexual abuse in out-of-home care.

Other volumes discuss in detail the types of assistance survivors need during particular processes, namely:

- referral to advocacy and support and therapeutic treatment as part of a best-practice response to complaints of child sexual abuse in institutional contexts (Volume 7, *Improving institutional responding and reporting*)
- advocacy and support and therapeutic treatment when accessing historical records of being in care (Volume 8, *Recordkeeping and information sharing*)
- counselling throughout the redress process, plus financial advice, legal advice, and ongoing counselling and psychological care as required by survivors who are eligible for redress (*Redress and civil litigation* report)<sup>10</sup>
- witness support as part of criminal justice responses (*Criminal justice* report).<sup>11</sup>

## 1.4 Key terms

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The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are described below. A complete glossary is contained in Volume 1, *Our inquiry*.

## Advocacy

‘Advocacy’ can mean different things to different people and there are many ways to undertake advocacy.<sup>12</sup> For this volume, advocacy refers to a wide range of activities to promote, protect and defend victims’ and survivors’ human rights and their rights to services and information.<sup>13</sup> It may involve assisting victims and survivors to express their own needs, access information, understand options and make informed decisions.<sup>14</sup>

There are several forms of advocacy. Self-advocacy is where an individual or a group of individuals represent their own needs and rights. Advocacy can also involve advocating *for* individuals and groups. It may occur on behalf of the client with their consent, or in partnership with them.<sup>15</sup> It is often accompanied by practical assistance to navigate service systems or meet basic needs such as transport, accommodation and financial assistance to access services.

Systemic advocacy involves promoting changes to systems that are perpetuating inequities and injustices.<sup>16</sup> By operating at a system level, it aims to benefit many by contributing to a more respectful and just society.<sup>17</sup>

Advocacy is a function of many services across the broader service system. Advocacy for individuals is often a component of direct service delivery and a part of many practitioners’ roles.<sup>18</sup> It can be provided by qualified practitioners, for example, psychologists and social workers, or by peers or survivor-led organisations. Some services make advocacy support roles visible by employing advocates. Others incorporate advocacy within broader functions.

## Collective trauma

‘Collective trauma’ (also sometimes referred to as historical trauma) is the ‘cumulative emotional and psychological wounding, over the life span and across generations, emanating from massive group trauma experiences’.<sup>19</sup> It is a shared, unfolding grief and loss experienced by Aboriginal and Torres Strait Islander peoples.<sup>20</sup> We use the term to refer to trauma caused by the decimation of Aboriginal and Torres Strait Islander populations during colonisation and the ongoing effects of this over many generations. This also recognises how destruction of language, culture, connection to Country and lore has disrupted social relations and healing practices integral to Aboriginal and Torres Strait Islander wellbeing.<sup>21</sup> The sexual abuse of Aboriginal and Torres Strait Islander children in institutions is part of the experience of collective trauma.

## Complex trauma

There is an emerging clinical awareness that trauma resulting from interpersonal abuse that is prolonged or repeated, including child sexual abuse, has a different nature and impact than that which is the consequence of an individual traumatic event.<sup>22</sup> When a person experiences repeated trauma, particularly in childhood and from a person in whom they are expected to place a substantial amount of trust, they are not only at risk of anxiety, intrusion and other symptoms of post-traumatic stress disorder (PTSD), but they also face difficulties in basic areas of healthy development including ‘the integrity of the body; the development of a healthy identity and a coherent personality; and secure attachment, leading to the ability to have healthy and reciprocal relationships’.<sup>23</sup> When discussing this form of trauma, the literature uses the phrases ‘complex trauma’, ‘complex post-traumatic stress disorder’ and ‘disorders of extreme stress not otherwise specified (DESNOS)’.<sup>24</sup> Throughout this volume we use the term ‘complex trauma’.

## Cultural appropriateness

The term ‘cultural appropriateness’ refers to ‘an approach to policy, intervention, service delivery and inter-group interaction that is based on the positive acceptance of the cultural values and expectations’ of an individual and their community.<sup>25</sup>

## Cultural safety

In this volume, the term ‘cultural safety’ refers specifically to Aboriginal and Torres Strait Islander peoples. Cultural safety means an environment ‘where there is no assault, challenge or denial of [a person’s] identity, of who they are and what they need’.<sup>26</sup> This encompasses Aboriginal and Torres Strait Islander individuals’ own assessment of their safety and capacity to engage meaningfully, on their own terms with a non-Indigenous person or institution. This requires action from the non-Indigenous person or institution to listen, enable and support these environments, with accountability to Aboriginal and Torres Strait Islander colleagues or service users.<sup>27</sup>

## Intergenerational trauma

‘Intergenerational trauma’ is when the impacts of any trauma are transmitted from an individual survivor to their children or grandchildren. We use the term to refer to the compounding, ‘ripple’ effects of child sexual abuse, across generations. When the concept of intergenerational trauma is used in the context of Aboriginal and Torres Strait Islander peoples and other indigenous communities in colonised nations, it refers to the collective experience of ongoing trauma over many generations.<sup>28</sup> (See also ‘collective trauma’).

## Secondary victims

The phrase ‘secondary victims’ is used in this volume to refer to people who are affected by the sexual abuse perpetrated against the primary victim (the child who is sexually abused). Secondary victims can include partners, parents, children (including children born as a result of the abuse), siblings and extended family. The impacts of child sexual abuse can also be felt by a wider range of people, including whistleblowers and other people (including other children) within the institution where the abuse occurred. There may also be collective trauma impacts for entire communities.

## Support

In this volume, ‘support’ refers to emotional and practical assistance provided to victims and survivors to reduce feelings of isolation and promote connections and trusted relationships for healing and recovery. Support is often a key component of advocacy. It can also be a discrete function of a group or service.

## Therapeutic treatment

In this volume, ‘therapeutic treatment’ is an overarching term to cover a range of evidence-informed interventions that address the psychosocial impacts of child sexual abuse. These treatments seek to improve victims’ physical, psychological and emotional wellbeing, and enhance quality of life. Therapeutic treatment can include counselling, psychotherapy, body therapies, therapeutic groups and psychiatric care that may include prescribed medications. These treatments can be delivered for individuals, families or broader groups, over the short or long term. They may be tailored to meet the victim’s needs. Therapeutic treatment is usually provided by qualified or accredited professionals such as social workers, psychologists or psychiatrists, with more specialist clinical interventions delivered by trained mental health professionals.

## Trauma

‘Trauma’ refers to an event that is extremely harmful or distressing, such as experiencing or being threatened with sexual violence. The word also refers to a person’s psychological response to the distressing event, immediately and over the medium and long term.<sup>29</sup> In reference to child sexual abuse, we use ‘trauma’ to describe experiences of abuse and institutional responses to it, as well as the ongoing impact they have on the survivors’ psychological wellbeing. Traumatic events ‘involve threats to life or bodily integrity, or a close encounter with violence and death’ which can ‘overwhelm the ordinary human adaptations to life’ and ‘confront human beings with the extremities of helplessness and terror’.<sup>30</sup> The overwhelming distress

associated with the traumatic event can cause a range of ongoing psychological problems, including depression, anxiety, nightmares and flashbacks, hyper-arousal (heightened anxiety and alertness) and hyper-vigilance, hypo-arousal (delayed or weakened physical and cognitive responses) and dissociation, feelings of helplessness, problems with concentration and an exaggerated startle response.<sup>31</sup> Experiences of trauma can inhibit survivors' capacity to regulate their emotional states.<sup>32</sup>

When diagnosing individuals with post-traumatic stress disorder (PTSD), clinicians use a specific set of criteria related to the type of experience and its ongoing psychological consequences. Our use of the word 'trauma' does not necessarily imply a formal diagnosis.

We discuss the effects of trauma on children's development further in Volume 3, *Impacts*.

## Trauma-informed

'Trauma-informed approaches' refers to 'frameworks and strategies to ensure that the practices, policies and culture of an organisation, and its staff, understand, recognise and respond to the effects of trauma on client wellbeing and behaviour'.<sup>33</sup>

The key principles of a trauma-informed system of care include:<sup>34</sup>

- 'having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and people's functioning
- ensuring that organisational, operational and direct service-provision practices and procedures promote, not undermine, the physical, psychological and emotional safety of consumers and survivors
- adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches
- recognising and being responsive to the lived, social and cultural contexts of consumers (for example, recognising gender, race, culture and ethnicity), which shape their needs as well as recovery and healing pathways
- recognising the relational nature of both trauma and healing'.

A trauma-informed approach is distinct from trauma-specific interventions or therapeutic treatments.<sup>35</sup> These interventions are part of, but not the same as, a system-wide trauma-informed approach. A trauma-informed approach does not require a service to provide therapeutic treatment addressing the symptoms of trauma.

## Victim and survivor

We use the terms 'victim' and 'survivor' to describe someone who has been sexually abused as a child in an institutional context. We use the term 'victim' when referring to a person who has experienced child sexual abuse at the time the abuse occurred. We use the term 'survivor' when referring to a person who has experienced child sexual abuse after the abuse occurred, such as when they are sharing their story or accessing support. Where the context is unclear, we have used the term 'victim'.

We recognise that some people prefer 'survivor' because of the resilience and empowerment associated with the term.

We recognise that some people who have experienced abuse do not feel that they 'survived' the abuse, and that 'victim' is more appropriate. We also recognise that some people may have taken their lives as a consequence of the abuse they experienced. We acknowledge that 'victim' is more appropriate in these circumstances. We also recognise that some people do not identify with either of these terms.

When we discuss quantitative information from private sessions in this volume, we use the term 'survivor' to refer both to survivors and victims who attended a private session and those (including deceased victims) whose experiences were described to us by family, friends, whistleblowers and others. This quantitative information is drawn from the experiences of 6,875 victims and survivors of child sexual abuse in institutions, as told to us in private sessions to 31 May 2017.



## 1.5 Structure of this volume

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**Chapter 2** presents what we learned about the support needs of victims and survivors and why advocacy and support and therapeutic treatment services are part of a holistic response. The chapter outlines the nature of victims' and survivors' needs, which is essential to understanding the extent to which services are responsive. It describes how advocacy and support and therapeutic treatment assist victims and survivors. We also explain principles for healing and recovery to guide the design of service system responses to victims and survivors.

**Chapter 3** describes current services providing advocacy and support and therapeutic treatment. This description demonstrates the breadth and siloed nature of service systems and how this is inconsistent with the nature of victims' and survivors' needs. It also outlines relevant reforms to service systems which affect the services that victims and survivors use.

**Chapter 4** examines the challenges that prevent services from responding effectively to victims' and survivors' needs. It explains the barriers they face when accessing services, and the systemic and structural issues that limit effective service responses.

**Chapters 5 and 6** outline our conclusions and recommendations about improving service systems to better respond to the needs of victims and survivors.

# Endnotes

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## 2 The need for advocacy and support and therapeutic treatment services

### 2.1 Overview

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This chapter describes what we have learned about the range of services victims and survivors need to support their recovery. We summarise what research, practice wisdom and survivors have told us would be helpful for service providers and funders to know, when working with children and adults who experienced childhood sexual abuse in institutions.

Every individual is unique, but through our work we have become aware of common themes. Thousands of survivors told us they drew on different sources of personal strength to get through and make sense of the trauma they had experienced. Survivors told us they received assistance from their support networks, including family and friends.

Many survivors also told us they sought assistance from services to cope with the impacts of institutional child sexual abuse. In addition they sought help to navigate the myriad service systems with which they had to engage, to gain assistance.

Advocacy and support and therapeutic treatment services are part of a holistic service response to victims and survivors. Implemented well, these services can empower victims and survivors, assist them to cope with impacts associated with institutional child sexual abuse and provide support to recover from trauma.

A system-wide response is needed to address all aspects of victims' and survivors' wellbeing, which may include financial, legal, medical, psychological, spiritual and other forms of assistance. We are of the view that, to be responsive to victims' and survivors' interconnected needs and promote healing and recovery, the service system should be trauma-informed and have an understanding of institutional child sexual abuse. Services within an effective system are collaborative, available, accessible, acceptable and high quality. Aboriginal and Torres Strait Islander healing approaches are part of a trauma-informed service system.

### 2.2 Understanding victims' and survivors' needs

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Survivors' journeys of recovery are influenced by numerous factors and are unique to the individual. At various times of their lives, depending on their circumstances, many survivors need assistance from services to cope with the impacts of institutional child sexual abuse and to navigate the myriad service systems that they may have to engage with to gain assistance.

### 2.2.1 The need for assistance to cope with the impacts of child sexual abuse

In public hearings, private sessions, written accounts and our consultation processes, we heard from thousands of survivors and their families about dealing with the aftermath of child sexual abuse and institutional responses to the abuse. Each person's experience was unique, although commonalities emerged, highlighting valuable lessons for the future reform of the service system. We heard stories of healing, recovery and finding peace. We also heard of experiences of great difficulty. In several private sessions, family members told us of a loved one whose life was cut short by suicide.

Volume 3, *Impacts* details what we learned about the profound and lasting impacts of child sexual abuse on victims and survivors. No victim is affected by child sexual abuse in the same way, but thousands of survivors told us they experienced the abuse as traumatic. The trauma caused by such abuse during childhood can alter a child's fundamental view of how the world functions, leaving them with sometimes uncontrollable feelings of rage, shame or disgust.<sup>1</sup> Children who have experienced child sexual abuse may need assistance to address the negative impacts it has had on their development, including its disruption to their relationships with parents or carers.<sup>2</sup> In addition to managing the symptoms of trauma, some survivors also need assistance to manage issues arising from coping and survival strategies, such as substance use.<sup>3</sup> Trauma can affect a child's brain functioning, mental and physical health, schooling and sexual behaviour, and the child may need support in all these areas.<sup>4</sup>

The detrimental impacts of child sexual abuse, particularly when not addressed, can emerge or develop further in adulthood, often compounding the effects of other adverse life experiences. Some survivors may experience severe consequences to their mental health, including emotional issues,<sup>5</sup> depression,<sup>6</sup> anxiety,<sup>7</sup> post-traumatic stress disorder,<sup>8</sup> eating disorders,<sup>9</sup> alcohol and other drug use,<sup>10</sup> and suicidality.<sup>11</sup> These issues range in severity, with some survivors facing complex and ongoing mental disorders related to past trauma. In addition to support for mental health needs, survivors may require support to cope with impacts related to their physical health,<sup>12</sup> interpersonal relationships,<sup>13</sup> culture,<sup>14</sup> spirituality,<sup>15</sup> sexuality and gender identity,<sup>16</sup> and social and economic wellbeing.<sup>17</sup>

We heard about a variety of strategies that individuals used to help them survive. Many survivors drew on sources of personal strength and meaning to manage the impacts of the trauma they had experienced.<sup>18</sup> Some pursued work, education or other goals.<sup>19</sup> Some responded by disconnecting and becoming numb to the trauma.<sup>20</sup> Victims and survivors also drew on strong, supportive relationships, including with family members, partners and friends.<sup>21</sup> Some engaged in sport, art and other creative activities.<sup>22</sup> In private sessions and our consultations with Aboriginal and Torres Strait Islander survivors, we heard of the importance of support drawn from kin and community networks.<sup>23</sup>

Many victims and survivors also seek assistance from formal services to help manage the impacts of child sexual abuse and institutional responses, and, due to the complexity of the service system, sometimes need help to access and navigate the system itself. The following sections discuss the needs of victims and survivors in seeking support from services and navigating the service system.

## Assistance from services

During our inquiry, we learned that the various systems of support services play a substantial role in the lives of many victims and survivors.

While there is limited research on the use of services by victims of child sexual abuse, including in an institutional context, studies suggest that survivors are over-represented in mental health services. For example, a study of 1,612 survivors of child sexual abuse in Victoria found they had higher rates of mental health treatment in public inpatient and community mental health services than a sample from the general population.<sup>24</sup> Research also suggests that clients of mainstream mental health and alcohol and other drug services are more likely to have histories of child sexual abuse than the general population.<sup>25</sup> There is also some research evidence that survivors are more likely to be users of health services.<sup>26</sup>

We commissioned a study asking survivors about pathways to support services. The study highlighted that victims and survivors can often engage with a wide range of services during their lives, including doctors and other medical professionals, counselling, police, legal, sexual assault, mental health, advocacy and peer support services.<sup>27</sup>

More than half of the survivors (55.7 per cent) who attended our private sessions and provided information about the impact of the sexual abuse described experiencing negative education and economic outcomes. This is consistent with research into this issue.<sup>28</sup> The range of impacts on mental health, interpersonal relationships, physical health, societal interactions, education, employment and economic security experienced by survivors means they may be more likely than the broader population to need assistance from various support services, including Centrelink, health, housing, education and employment services.

While each individual has unique support needs, additional needs emerge from the shared experiences of groups of survivors. As discussed in Volume 8, *Recordkeeping and information sharing*, care-leavers (those who have spent time in institutional care or out-of-home care as a child or youth, or both) may require assistance to access their records and, where appropriate, to seek to amend or annotate records. In addition, submissions to *Issues paper 10: Advocacy and support and therapeutic treatment services (Advocacy and support and therapeutic treatment services)* stressed that many Aboriginal and Torres Strait Islander survivors sought assistance with reconnecting to culture, family and community, as part of healing.<sup>29</sup>

Many services that work with survivors highlighted that individuals dealing with the impacts of sexual abuse need special assistance. They argued that survivors should be recognised as a special group, requiring priority access to social, housing, healthcare, education, mental health and employment services.<sup>30</sup>

## Assistance to navigate service systems

In addition to social and health services, victims and survivors may engage with child protection, police and legal services for issues such as reporting their experience of abuse or accessing historical records. The mental, physical, social and economic impacts of abuse can compound the difficulty of navigating already complicated service systems and processes. Services often hold a great deal of authority over the people with whom they interact, which can exacerbate fears victims' and survivors' may already hold arising from their experiences of child sexual abuse in institutions. Practical issues like transport costs and paperwork can present barriers for victims and survivors experiencing a range of distressing issues. In a submission to our *Advocacy and support and therapeutic treatment services* issues paper, one survivor described how her experience of being abused while in institutional care affected her everyday life:

As a result of being institutionalised I have struggled with basic daily living etc., self care, and managing emotions and completing simple tasks like shopping, participating in any normal activities due to depression and isolating myself. The effects of the abuse from being in state care mean that I rely on others to assist me. It has taken me years to be able to even find advocates and people in the community who provide simple assistance like attending appointments, due to me having severe panic attacks and dissociation.<sup>31</sup>

The need for assistance to navigate service systems can be acute for some groups. For example, national disability rights and advocacy organisations Children and Young People with Disability Australia and People with Disability Australia told us in response to our *Advocacy and support and therapeutic treatment services* issues paper that individual advocacy for people with disability is essential to support their access to services in the context of a disjointed service system and a workforce with limited skills and expertise.<sup>32</sup>

We were told that some Aboriginal and Torres Strait Islander survivors faced additional barriers when accessing mainstream services. These included a fear or reluctance to seek help due to past experiences of injustice and an expectation of being negatively judged by non-Indigenous workers.<sup>33</sup> We heard of a range of frustrations faced by Aboriginal and Torres Strait Islander survivors accessing mainstream services, including a lack of understanding of: stigma around sexual abuse from Aboriginal or Torres Strait Islander perspectives; kinship systems and family dynamics; and the impact of colonisation on present-day grief, loss and trauma.<sup>34</sup> Advocacy can assist Aboriginal and Torres Strait Islander survivors to find culturally safe mainstream services.<sup>35</sup>



Care-leavers are another group that has particular assistance needs. The Care Leavers Australasia Network (formerly Care Leavers Australia Network) told us that access to records was an important issue for care-leavers<sup>36</sup> and that care-leavers faced a range of issues in obtaining records.<sup>37</sup> The national peak body for young people in out-of-home care, CREATE Foundation, told us that children and young people in out-of-home care should be supported to access records in an age-appropriate way that is sensitive to their lived experiences.<sup>38</sup> We were told that challenges facing older care-leavers in accessing records were compounded by literacy issues arising from educational deprivation.<sup>39</sup> In addition, we heard of the negative impact on survivors when elements of their personal records had been redacted.<sup>40</sup>

### 2.2.2 The nature of victims' and survivors' needs

Victims and survivors have diverse needs. An individual's age, gender, location, cultural background, circumstance, abilities and experiences of abuse, including the institution in which the abuse occurred, all influence the type of assistance they need. For example, a five-year-old who has experienced child sexual abuse may need child-centred therapeutic treatment, a male victim may find a male practitioner helpful, and a victim who was abused in a religious institution may seek pastoral care. Service responses should be tailored to the diverse range of needs that victims and survivors face, yet coupled with a strong understanding of the shared experiences of various groups.

Through thousands of private sessions and written accounts we heard about the pervasive impacts of child sexual abuse. These impacts can be experienced simultaneously or as a cascade of effects over a survivor's life. Support service responses should be able to respond to the multiple needs arising from child sexual abuse. The service system should also be responsive to the dynamic nature of victims' and survivors' needs throughout their life course.

#### Multiple needs

Volume 3, *Impacts* establishes that the effects of child sexual abuse and institutional responses to it on victims' mental and physical health, interpersonal relationships, culture, spirituality, sexuality, gender identity and social and economic wellbeing are interconnected. Some survivors said they developed substance abuse problems after using alcohol or other drugs to manage the psychological trauma of sexual abuse, which subsequently affected their physical and mental health or led to other problems in their lives. For example, one survivor, 'Yannis', explained the knock-on effect his drug dependency has had on his life since the sexual abuse:

I've lost everything. I've lost my family, I've lost my kids. I've lost my freedom. I've lost a lot of things. My family, they have nothing to do with me because of my addiction. I've been on my own. And it's been hard, mate.<sup>41</sup>



He told us he now feels ready to deal with the sexual abuse, ‘to talk to someone about that instead of using the drugs ... I realise the drugs only block it temporarily, and in that temporary stage they’re creating bigger problems anyway’.<sup>42</sup>

To cope with the multiple impacts of child sexual abuse, survivors may concurrently need multiple types of support.<sup>43</sup> In our private sessions and consultation processes we were told about individuals accessing a range of services during their lives. One survivor described the various services she had used to manage the impacts of child sexual abuse she had experienced while she was a ward of the state. These included legal services, out-of-home care support services to trace her family history, practical support from a service for Forgotten Australians, psychiatric support, in-home peer support, alcohol and other drug treatment services, a therapeutic community she stayed in as a resident and victim support groups.<sup>44</sup>

Service responses should be coordinated to respond effectively to the multiple and interconnected needs of victims and survivors.

## Dynamic needs across the life course

The journey of recovery from child sexual abuse is not linear. The type of advocacy and support and therapeutic treatment that victims and survivors need and find helpful can change over time. In Volume 3, *Impacts* we explain in some detail how child sexual abuse can affect a child’s psychosocial development and how these effects manifest differently at different developmental stages. The research literature suggests that the effects of sexual abuse can become apparent at any stage in a survivor’s life.<sup>45</sup> This is consistent with research we commissioned that analysed life journeys of survivors.<sup>46</sup> One survivor told us that, as she grew older, memories of abuse continued to impact her life. ‘The memories, they get more clearer, like I’m going back ... things flash up every now and again ... I’m frightened about what’s really hidden in the back of my brain.’<sup>47</sup>

Research tells us there are significant times in life that can be turning points for recovery.<sup>48</sup> Victims and survivors can face critical points in their lives that might heighten experiences of trauma, creating a greater need for therapeutic support. Critical points can include the birth of a child, early parenting activities such as breastfeeding, periods of mental or physical illness, a survivor’s child reaching the age they were when they were abused, ageing and periods of grief or loss.<sup>49</sup> Each of these experiences can trigger difficulties, emotional distress and a lack of confidence.<sup>50</sup> These issues can be seen in ‘Margret’ and ‘John’s’ story.

### **‘Margret’ and ‘John’**

After her mother died, ‘Margret’ went with her father to live with his parents in Queensland. The subsequent death of ‘Margret’s’ grandmother coincided with the local priest showing an increased interest in ‘Margret’s’ welfare. ‘Margret’ told us that, when she was 10 years old, he sexually abused her in her home, the monastery and the church confessional, threatening her constantly that she wasn’t to tell anyone.

‘Margret’ told us that she’d been frank about the abuse in later years, telling her husband, children and a few trusted people. ‘Margret’ said that when her son ‘John’ was an adult, she found out that he had also been sexually abused, by a teacher.

‘Margret’ said she had become increasingly aware of the triggers of her own abuse as her children were growing. ‘You talk about impacts. You get to your life and think, “I’m okay, I’ve done well. I’ve got a great family, I’m a good person, I’ve never hurt anybody”, but the effects it has on you, like I think having my daughter last, that triggered a lot of emotions in me, a lot of emotions of protection. I had a lot of difficulty cleaning her, touching her. It took so much strength to overcome those fears that I could have some sort of meaningful relationship with this little girl. You’re their mother. You’re the carer. You have to do these things and it was really, really hard.’

‘Margret’ said ‘John’s’ response to being sexually abused as a child was to over-achieve. ‘There was never a moment where he would just relax’, she said. In his twenties, ‘John’ completed two university degrees and another professional qualification. At 30, however, he experienced a severe grief reaction to the accidental death of someone for whom he felt responsibility, and took his own life.<sup>51</sup>

The triggers that affected ‘Margret’ and ‘John’ were unpredictable and took a long time to emerge. Like many survivors of child sexual abuse, ‘Margret’s’ and ‘John’s’ coping mechanisms were effective for a long time until they were disrupted in unforeseeable ways by life events.<sup>52</sup> Support may be required at different points throughout a survivor’s life, and may also need to align with the coping mechanisms that survivors have adopted independently. One survivor told us:

It should be recognised that for victims who have suffered for years and have not received any or very little adequate help, that help may be required for the rest of our lives as behaviour and coping mechanisms have become entrenched over the many years since the sexual abuse.<sup>53</sup>

Service responses should be adaptable to the dynamic needs of victims and survivors and their families, during childhood and throughout their adult life.

## Children and young people

Children and young people disclose sexual abuse differently to adults. In Volume 4, *Identifying and disclosing child sexual abuse*, we describe how they may make indirect or partial disclosures to test the response they receive.<sup>54</sup> In submissions, we were also told children and young people often do not disclose initially,<sup>55</sup> or they disclose abuse through emotional or behavioural changes such as angry outbursts, running away or withdrawal.<sup>56</sup> Research confirms a child's capacity to describe what has happened to them and engage in therapeutic work is shaped by their age and cognitive capacity, whether or not they have an intellectual disability and tactics used by perpetrators to impose secrecy.<sup>57</sup>

Services for children and young people should consider the child's developmental capabilities and the potential impacts of sexual abuse related to their age and developmental stage.<sup>58</sup> We were told early intervention services should be available for children who have been sexually abused.<sup>59</sup> In addition, we were told services need to be able to undertake longer-term work to build trust and engage effectively with children and young people.<sup>60</sup> The South Eastern Centre Against Sexual Assault in Victoria told us that practitioners working with children who have been sexually abused need to have specialist expertise and be appropriately qualified.<sup>61</sup> Other service providers suggested education and training should be available to improve workforce capacity to respond to children's particular needs.<sup>62</sup>

Some needs – such as emergency medical attention and child protection responses – are immediate and temporary. Others – such as the need for therapeutic treatment to address trauma – can emerge later in life. In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse)*, Ms Karen Hogan, manager at specialist sexual assault service for children and their families, The Gatehouse Centre, described emerging therapeutic needs in adolescence, years after experiences of sexual abuse:

one of the things that we find working with children and young people is if they disclose abuse at a young age, then what they are needing to do is work with us for a time in having assessments and treatment, then they might come back when they are 12, 13, 14, because the abuse has had an impact on their further development at that age and stage that they are at, so that we find that children and young people and their families are having to revisit the abuse in a therapeutic sense, as well as, obviously, to live it, as they go through their childhood ...<sup>63</sup>

Relationships with caregivers are important for service delivery to children and young people. In submissions to our *Advocacy and support and therapeutic treatment services* issues paper, children's services told us that working effectively with children involves engaging with non-offending parents, carers and family members.<sup>64</sup> In the *Nature, cause and impact of child sexual abuse* case study, Ms Hogan also spoke about the importance of working with families:

in whatever form that takes, and that is often not biological family, but it's the key significant adults in their life ... to assist them to move forward and to be able to make some sense of what has happened to them.<sup>65</sup>

Ms Hogan elaborated on the ripple effects of trauma, which must also be considered when working with families of abused children:

the families are really, obviously, severely impacted. There is guilt, there is shame, there is anger. They have often that same mistrust of the world that their child or young person has, from the disclosure of abuse, and ... in our clinical practice, 72 per cent of the mothers have been abused themselves, and this is often the first time they have disclosed as well. So they are also in a very vulnerable situation at the time of the disclosure.<sup>66</sup>

In addition to providing developmentally-appropriate services and involving caregivers in the response, recovery for children and young people can be supported by others in the broader context in which they live. In the Australian Psychological Society's response to our *Advocacy and support and therapeutic treatment* issues paper, we heard that educational settings play an essential role in children and young people's development and may 'inadvertently re-traumatise' children and young people if they are not aware of the ways trauma affects behaviour and hinders learning experiences.<sup>67</sup> Research suggests that non-clinical settings – including home, school and community – play an essential role in healing and recovery for children and young people who have experienced trauma.<sup>68</sup> This was also raised in the *Nature, cause and impact of child sexual abuse* case study. Speaking in relation to in-school support for children with histories of trauma, Professor Louise Newman, a psychiatrist, told us that developmentally appropriate and trauma-informed therapeutic and broader supportive environments are necessary for healing. She said support for children with histories of trauma:

needs to involve not just mental health services. That needs to be a mental health focus and a trauma focus within educational facilities that can help children, firstly, understand what they're experiencing, protect children from overdiagnosis or misdiagnosis, and particularly the use of psychotropic drugs that are not going to be effective for trauma related syndromes ... Most importantly for the children is to help them regain their capacities for positive experiences, educationally, greater self-esteem, and there are actual remedial programs that could help children, who are traumatised and anxious, with their focus and attention.<sup>69</sup>

## Adults and older people

Some victims may not experience debilitating or obvious impacts of child sexual abuse in the short term,<sup>70</sup> but their problems can increase with age.<sup>71</sup> Sometimes negative impacts on health and wellbeing are formed in childhood, but only emerge as symptoms later in life. As noted, other times a significant life event will trigger a memory or trauma response. Some survivors do not make the connection between their experience of child sexual abuse and difficulties such as addiction, relationship breakdown and mental health issues until they are much older. It is increasingly understood that as survivors have new experiences or enter a new stage of development, the consequences of sexual abuse in childhood may manifest in different ways.<sup>72</sup>

In the *Nature, cause and impact of child sexual abuse* case study, AOA described the impacts of the sexual abuse he had experienced 54 years ago, telling us of the myriad physical, psychological and interpersonal consequences. He also described the therapeutic treatments he accessed, including with his partner, to supplement the support provided by his family and friends.

## AOA

AOA told us of a range of inflammatory diseases he suffers, including: painful cystitis, urinary tract infections and prostatitis; pelvic inflammatory disease; irritable bowel syndrome; asthma; bronchitis; sinusitis; arthritis; oedema and pneumonia. He explained complex post-traumatic stress disorder has had a big impact on his life and he has experienced chronic insomnia, hyper-arousal, panic, dissociation, numbing and depression. He also told us of intrusive images of self-harm and that he experiences 'ongoing confusion between sex and affection with close friends'.<sup>73</sup> While he has been happily married for 22 years, he told us he can quickly move between anxious dependency and dismissive detachment:

At times inside the marriage I appear to be emotionally connected and engaged, but I am not present. I am watching myself acting emotions, watching my life from a distance, and inside me I feel detached, isolated and depressed. Surrounded by people who love me and are deeply bonded to me, I can feel alone.<sup>74</sup>

He told us in one instance, after months of seeing images of self-harm in his mind, without realising what he was doing he acted this out in front of his 12-year-old son, pulling the blunt side of a knife across his wrist. Seeing the effect of this on his son in that moment and over the next few weeks made AOA return to therapy. He believed this meant he was a failure and he felt 'profound shame' at needing to do this. He said he sometimes sabotaged the process, but his partner and the therapist 'pulled me back in'.<sup>75</sup> AOA explained that:

happily in the last twelve months I have had none of my usual respiratory tract, pelvic floor or urinary tract ill health ... I attribute some of that to the influence of family and friends, of lifestyle and body-oriented psychotherapies.

Around the same time, he and his partner have begun couples therapy and he told us this has helped them to identify and respond more appropriately to trauma triggers.

AOA expected to continue to need therapy, both individually and with his partner, using body-oriented and trauma-informed methods. He explained that 54 years on, he is experiencing the impacts of grooming as 'far more damaging than the physical acts of sexual abuse'. He said, 'the invisible trauma wounds affect my relationships everywhere, even down to the struggle to go for help when I so obviously need it'.<sup>76</sup>

Reflecting on AOA's story, psychiatrist Professor Louise Newman discussed the growing understanding of traumatic childhood experiences on physical and mental health in adulthood:

There's a lot more research trying to understand the mechanisms behind that, but I think as Mr AOA noted, the impact on the immune system is something that's becoming apparent, that particularly when we're talking about early abuse, when the immune system is literally being set up and established, if those core processes are disrupted, that, as far as we understand currently, can set up ongoing deficits in immune regulation so that the body is exposed.<sup>77</sup>

As survivors move into their later years there may be issues of cognitive decline or experiences that trigger memories of the child sexual abuse. As a result, survivors may need sensitive, trauma-informed support. In the *Nature, cause and impact of child sexual abuse* case study, Dr Philomena Horsley, Research Fellow at La Trobe University, described significant issues for older survivors that are often not recognised. Dr Horsley said:

as people age and become older, particularly those in their 70s and 80s and 90s, there's a physical frailty, there's often a cognitive impairment of some kind, or moving into that space, as well as, in a social sense, greater isolation from networks, particularly if one is in care or going into care, and so lack of support. I think what can happen is as those feelings of vulnerability and lack of safety occur in someone's life, it can re-trigger memories, either specific memories or just a more generalised sense of feeling vulnerable, not feeling safe, feeling a lack of control about their physical surroundings, whether they're in a family home or whether they're in an aged care facility or whether they're in a prison, for instance, which I think is a really under-recognised area. People become less physically mobile, so less a sense of empowerment in themselves.<sup>78</sup>

Institutionalised care is a particular concern for survivors of child sexual abuse in institutional contexts. Through our consultation process we heard about the particular needs of older care-leavers, including members of the Stolen Generations, Forgotten Australians and Former Child Migrants.<sup>79</sup> A submission to our *Advocacy and support and therapeutic treatment services* issues paper discussed the need for assistance to access aged care services, particularly supported accommodation in non-institutional settings, because care-leavers are typically unwilling to spend their last stage of life in an aged care institution.<sup>80</sup> The submission also highlighted the need for assistance to deal with wills and probate, pay funeral expenses and access personal records, including obtaining free copies and challenging inaccuracies in records.<sup>81</sup> As Professor Newman told us in the *Nature, cause and impact of child sexual abuse* case study:

this highlights the importance of having a developmental approach. The end of life clearly is hugely significant psychologically for people who are trying to often make peace with or come to terms with, as best they can, experiences they might not have had other opportunities to, but I think the issue is we currently don't have the approach within services.<sup>82</sup>

What we have heard about the impacts of trauma on children's development, the manifestation of trauma symptoms throughout adulthood and the often unidentified needs of older survivors, underscores the need for a life course approach to service delivery. This is important for individual service responses and for the overall design of the service system.

### 2.2.3 The needs of secondary victims

Secondary victims of child sexual abuse are individuals who are negatively affected by the abuse perpetrated against the primary victim. They often need assistance to deal with the impacts on their own wellbeing, as well as to support the victim.

In most cases, secondary victims have a close relationship with primary victims. They may include victims' partners, children, parents, siblings and extended family members.<sup>83</sup> While their experiences are different from those of victims themselves, secondary victims can nevertheless be devastated by the impacts of abuse on their loved ones and the way institutions respond to it.<sup>84</sup>

In Volume 3, *Impacts* we discuss effects felt by a wider range of people, including whistleblowers, classmates and friends of the victim and other people (including other children) in the institution where the abuse occurred. In some situations, the impacts of child sexual abuse can have ripple effects throughout a community or across generations of families. Community connectedness can be shattered by the revelation of child sexual abuse, especially when the perpetrator is well liked or the institution is respected or trusted. The breakdown of community cohesion can be intensified if large-scale abuse is revealed, or attempts by the institution to conceal the abuse are discovered. For Aboriginal and Torres Strait Islander communities, a history of colonisation and forced institutionalisation can mean that child sexual abuse has long-term and cumulative effects on the whole community. Cumulative effects of abuse and social disadvantage may contribute to survivors' children being placed in out-of-home care, continuing the pattern of institutionalisation across generations.



Volume 3, *Impacts* details the ripple effects of child sexual abuse and institutional responses on secondary victims. During the Royal Commission, we heard that secondary victims experienced adverse impacts on their mental health, relationships, family functioning, employment, financial security and social connectedness. ‘Secondary trauma’ is the term used to describe the emotional effects when an individual hears firsthand about the trauma experiences of another. Trauma literature suggests that secondary traumatic stress can mirror the symptoms of post-traumatic stress disorder.<sup>85</sup> Through our consultation process we were told that there is a lack of understanding about the grief and trauma that secondary victims face. For example, one parent told us about her struggle to create a support network to assist her and her husband with the impacts of their child’s abuse:

My husband and I have suffered the most unimaginable traumas; traumas which I would not wish on any parent ... We are silently broken, with no support. I have tried to instigate a group for parents in our situation but this has proven too difficult as I have encountered only inertia and I have not the stamina to push.<sup>86</sup>

Support for secondary victims can be particularly important because they often play a key role in caring for primary victims and their capacity to do this may be hindered by vicarious trauma.<sup>87</sup> Through our inquiry, we heard from parents about challenges they faced parenting and supporting a child who had been sexually abused, including managing a range of health and social issues such as drug and alcohol abuse, mental health, criminal activity, suicide attempts, unstable employment and the survivor’s difficulties in caring for their own children. For example, in *Case Study 2: YMCA NSW’s response to the conduct of Jonathan Lord*, AS told us about the ongoing impact on her and her family resulting from Jonathan Lord’s sexual abuse of her son, AH:

This year I started going to counselling sessions of my own because I needed strategies to help AH. In the past few years, my husband and I have been so focused on getting AH back and making sure that my daughter doesn’t miss out that I have pushed all my friends and family away. I felt like I couldn’t deal with the outside world. I am trying to rebuild those relationships now.<sup>88</sup>

The issues described by AS are consistent with what we have learned about the needs of other secondary victims. Research we commissioned examining the impact of institutional child sexual abuse on family relationships identified that family members’ needs as secondary victims can be compounded by their caregiving responsibilities to primary victims.<sup>89</sup> Research also suggests that where the primary victim is a dependent child, caregivers such as parents would benefit from assistance in dealing with the effects of child sexual abuse so that they can provide support to the primary victim.<sup>90</sup>

## 2.3 How advocacy and support assist victims and survivors

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This section describes what we learned during our inquiry about the ways in which advocacy and support assist victims and survivors of child sexual abuse.

Through our case studies, private sessions and consultation processes, we heard from thousands of survivors and their families, the services who work with them and governments about the importance of advocacy and support and how they assist in victims' and survivors' journeys of recovery. While few studies have systematically reviewed the outcomes of advocacy for victims and survivors of child sexual abuse, the available research regarding this and related fields, including sexual violence, children's advocacy and domestic violence, details positive and encouraging outcomes.

Combining these sources of information, we formed the view that advocacy and support functions are important components of an effective service system for victims and survivors. Well-implemented advocacy and support services can: help victims and survivors access resources and relevant information; help survivors connect positively with other survivors and families; aid in recovery from trauma; and decrease the risk of further abuse. Access to advocacy and support can also result in better mental health and other outcomes for victims and survivors and promote systemic improvements to service responses.

### 2.3.1 Facilitating responses to multiple needs

Advocacy can empower victims and survivors to navigate the complex range of services they may need. An effective advocate can assist a victim to access medical care, make a report to police, find a counsellor, attend education courses, join a local sporting club and raise awareness about matters affecting the victim. Advocacy can also play a role in connecting Aboriginal and Torres Strait Islander survivors with culturally safe services, helping people with disability to find a disability-competent service and linking people from culturally and linguistically diverse communities with culturally appropriate services.

### **‘Tommy’ and ‘Jenny’**

As a child, ‘Tommy’ had learning difficulties. Although a ward of the state, he was cared for in his early years by his grandmother. At age 12, he was sent to a Catholic boys’ home, where he stayed for two years. ‘Tommy’ told us that, during this time, he was sexually and physically abused by Brother ‘Neil Foley’.

‘It wasn’t a very nice place’, ‘Tommy’ said. ‘There were a lot of threats.’ He said that because of this, he did not disclose the abuse to anyone.

Many years later, ‘Tommy’ had some legal issues, and he was assisted in managing them by a local advocate, ‘Jenny’. In her role, ‘Jenny’ also took ‘Tommy’ to see a psychiatrist. It was during this visit that the psychiatrist asked him about the boys’ home. This was when ‘Tommy’ first told someone he had been sexually abused.

The assaults were then reported to the police who initially responded by saying that, ‘it was a long time ago’, but found after further investigation that ‘Tommy’s’ report backed up numerous other reports they had received.

‘Jenny’ approached the Catholic Church’s Towards Healing program, which offered a series of counselling sessions. ‘Jenny’ also supported ‘Tommy’ to access legal representation, which eventually led to a settlement of \$160,000.

‘Tommy’ continues to see a psychiatrist and a psychologist. He lives in a public housing flat, but has often had problems with his tenancy because of his hoarding behaviour. He also has trouble engaging with support providers. ‘I’m trying to make it better’, ‘Tommy’ said. ‘But sometimes it’s just hard.’

‘Jenny’s’ work with ‘Tommy’ continues.<sup>91</sup>

Advocates can assist victims and survivors who choose to seek therapeutic treatment to navigate the mental health system. This assistance could include identifying practitioners with relevant expertise, making referrals and brokering access to services.

Survivors who face immediate physical, economic or other hardships may not be in a position to effectively engage with therapeutic treatment. They may first require support to establish a sense of safety and stability and to have their immediate physical, economic or other needs met.<sup>92</sup> We heard that therapeutic treatment can be unhelpful if offered to a victim before these more immediate needs are met,<sup>93</sup> and that ignoring these pressing needs can impair the victim’s recovery and affect their ability to trust service providers.<sup>94</sup>

Advocacy and support services can assist victims and survivors to navigate systems for housing, health, education and social services. One study involving victims of sexual assault noted that the participants wanted a 'flexible and practical form of support' immediately after the abuse occurred.<sup>95</sup> Several support services working with victims and survivors of child sexual abuse told us how advocacy and support met immediate needs, including:

- emergency and ongoing housing<sup>96</sup>
- financial issues, including assisting in dealing with Centrelink<sup>97</sup>
- physical health issues, including dental and medical issues<sup>98</sup>
- education, training and employment services and opportunities<sup>99</sup>
- legal assistance, including dealing with police, attending court and making redress and civil litigation claims.<sup>100</sup>

Research suggests that dedicated advocacy roles for victims of sexual violence 'assist people to connect to services they need ... and improve the support and experience of people who have suffered violence and trauma'.<sup>101</sup> A 2013 pilot study in Victoria investigated the role of magistrate-led case management for cases involving child sexual abuse. It found this approach was effective in reducing delays in hearing cases, and therefore reducing delays in making decisions to connect children with necessary support services and placements.<sup>102</sup>

Evaluations of victim advocacy and support services have been encouraging. Child Advocacy Centres (CAC), such as the George Jones CAC in Western Australia, provide advocacy and support for victims of child sexual abuse and aim to bridge gaps between agencies. The CAC model has been found to be effective at assisting victims and their families to access community resources and increasing multidisciplinary responses to cases.<sup>103</sup>

Evidence for the efficacy of advocacy and support also comes from programs that support other groups. For example, advocacy and support for women with abusive partners can reduce the risk of further victimisation, increasing access to community resources, improving social support and fostering mental health and wellbeing.<sup>104</sup>

By facilitating service responses to the psychosocial impacts and broader impacts of child sexual abuse, advocacy and support are important in improving the wellbeing of victims and survivors.

### 2.3.2 Reducing experiences of isolation

Positive relationships can be sources of resilience and wellbeing,<sup>105</sup> yet many survivors told us that they live without the support of family or friends. Advocates and support workers can connect survivors to support groups or peer networks.

The Royal Commission heard a great deal about the value of peers in providing support.<sup>106</sup> In response to our *Advocacy and support and therapeutic treatment services* issues paper, we were told that support groups run by survivors can be powerful in reducing isolation and assisting recovery.<sup>107</sup> In *Case Study 25: Redress and civil litigation (Redress and civil litigation)*, we heard from Dr Cathy Kezelman, President of the Blue Knot Foundation (formerly Adults Surviving Child Abuse), a support service for survivors of childhood trauma. She told us how survivor-led organisations can assist:

obviously one of the core issues about having been abused is that you often feel very isolated, as if you're the only person, no one else understands, so that peer identity is absolutely critical, but also having an organisation that you believe understands and that can be with you and walk with you on the journey unconditionally, can be absolutely critical for the healing process ...<sup>108</sup>

Assisting survivors to become peer leaders is an important part of some organisations' model of care. Relationships Australia Victoria identified value in developing the peer workforce and including people with lived experience of institutional child sexual abuse in the provision of advocacy and support and therapeutic treatment services.<sup>109</sup> Tuart Place, a support service for care-leavers in Western Australia, believes creating opportunities for care-leavers to take leading roles in advocacy, organisational governance and community education is a key element of service.<sup>110</sup> In our *Nature, cause and impact of child sexual abuse* case study, we were told by the NSW Mental Health Commissioner John Feneley that the emerging model of peer-led mental health support is 'one of the most promising moves in mental health in Australia'.<sup>111</sup>

In private sessions, survivors told us of the value of supporting each other. 'Bert Terry' lived in a boys' home for 11 years from the age of five.<sup>112</sup> He told us that the culture of the home was violent and dehumanising and that sexual abuse was rife. For 'Bert Terry', his ongoing relationship with other men who grew up in the home has been transformative. He told us that, 'If you were to ask me [about the abuse] five years ago ... I would have told you to go and get stuffed. Because I was too ashamed ...'<sup>113</sup> He went on to say:

We sit down and talk now, we're not ashamed, we're not afraid to ask difficult questions ... we were flogged into submission and now, as older men, now it's our turn to ask the questions. It's our turn to be answered.<sup>114</sup>

In consultations with Aboriginal and Torres Strait Islander communities we heard from survivors who were part of well-established peer-based models of support and recovery. They engaged with us from a position of strength, built on their shared capabilities. An impact of institutional sexual abuse was damage to the victim's family and community ties. In the face of this isolation, groups had formed to design their own system of cultural healing and to find ways to reconnect.<sup>115</sup>

In research we commissioned capturing the practice knowledge from the Royal Commission support services, practitioners noted that participation in peer support groups can assist survivors to overcome feelings of isolation, guilt and betrayal by acknowledging shared experiences and maintaining involvement and connection.<sup>116</sup> A recent study found that the supportive bonds and sense of solidarity and shared experience developed through peer support can be particularly beneficial for older care-leavers, including those who are survivors of institutional child sexual abuse.<sup>117</sup> One care-leaver who participated in the study explained this strength in solidarity, where 'people can come together. They've had something in common as children. They don't necessarily need to talk about it'.<sup>118</sup>

Other research suggests that social and emotional support for victims of child sexual abuse significantly lowers symptoms of mental illness throughout their lives. Studies have shown that social support in adolescence and adulthood can moderate the long-term psychological impact of child sexual abuse, such as anxiety and depression.<sup>119</sup> In addition, support to increase self-esteem can prevent the development of symptoms of post-traumatic stress disorder among victims of child sexual abuse.<sup>120</sup>

### 2.3.3 Empowering survivors and improving service system responses

A significant dimension of child sexual abuse is the sense of powerlessness victims experience from being abused by a trusted person in a position of authority.<sup>121</sup> Advocacy and support can empower victims and survivors by providing safe opportunities for them to exercise control over decisions.<sup>122</sup> Some services promote self-advocacy, where individuals represent their own needs and rights.<sup>123</sup> Justiz Community, which provides advocacy services in regional New South Wales, told us that survivor-directed decision-making is a key principle that underpins successful responses to survivors.<sup>124</sup> The organisation said that it encourages survivors to take back power and control and to determine their own paths of recovery.<sup>125</sup>

Systemic advocacy is dedicated to reforming parts of the service system so it can better respond to and prevent child sexual abuse. Knowmore, a free legal advice service for people who engaged with the Royal Commission, told us that empowering survivors through facilitating their participation in decision-making can result in services more effectively addressing their needs:

Unsurprisingly, many of knowmore's clients often express a high level of mistrust of institutions or 'losing of a voice' when it has come to decisions being made about them; participating in decisions about what services they receive, and what happens to and for them, is important.<sup>126</sup>

Many people play a role in systemic advocacy. Survivors, their families and communities, services and governments can all influence the way systems respond to victims. In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, the Blue Knot Foundation recommended:

The collective voices of government and non-government agencies as well as of practitioners who work with survivors play a critical role in advocating for the needs of those who were disempowered in childhood and, in many cases, rendered voiceless then and now. Policy, practice and systems of support must be informed by survivors and the practitioners and agencies who work with them.<sup>127</sup>

During our inquiry we heard from survivors who had experiences with self-advocacy through a range of services. For example, in our *Redress and civil litigation* case study, Ms Jennifer Aldrick, a survivor, reflected on her experience as vice-chair of the board of Forgotten Australians Coming Together, the governing body of Tuart Place in Western Australia:

I would also like to see more involvement by care survivors in the governance of services for Forgotten Australians and Former Child Migrants. As is my experience, it is empowering for survivors to have opportunities to contribute and have a say in the running of their own services.<sup>128</sup>

The role of advocacy in improving system responses has been recognised in previous inquiries. In a 2015 inquiry report into neglect, abuse and violence against people with disability in institutional and residential settings, the Senate Community Affairs References Committee acknowledged the importance of advocacy:

The committee acknowledges the vital role that formal and informal advocacy plays in addressing violence, abuse and neglect of people with disability. However, the advocacy sector urgently needs greater assistance from all levels of government to continue in this role.<sup>129</sup>

The committee recommended that all levels of government acknowledge the role of advocacy by implementing measures such as increased training for people with disability to help them self-report abuse and advocacy programs to include training for informal advocates.<sup>130</sup> The committee also recommended increasing funding for advocates and self-advocacy programs to meet the increased demand anticipated under the National Disability Insurance Scheme.<sup>131</sup>

### 2.3.4 Increasing reporting of child sexual abuse

Several victims and survivors told us in private sessions that they disclosed their experience of sexual abuse to advocacy and support services. They told us how the services encouraged and helped them to disclose to others, such as the police. As discussed in Volume 4, *Identifying and*

*disclosing child sexual abuse*, advocacy groups for victims of abuse in institutions started to form in the 1990s, setting up helplines and support groups, and lobbying institutions to change their practices. We heard in *Case Study 28: Catholic Church authorities in Ballarat*, how publicity about survivors in Ballarat and the creation of a men's survivors' group encouraged men to come forward and disclose. One survivor, Mr Stephen Woods, gave evidence that after he had gone through criminal proceedings in relation to his experience of child sexual abuse, he decided to go public with his story to help other men come forward. He said:

After this, people started to contact my family or me, or Broken Rites [an advocacy and support group for survivors of church-related sexual abuse]. Usually they contacted Broken Rites, who gave them my number. As the victims came forward, it was quite literally like the dam bursting.<sup>132</sup>

Some survivors spoke of how these groups encouraged them to disclose to others, such as the police. One survivor told us that almost two decades after she was sexually abused by a priest, she saw an article about a priest who had been jailed. At the bottom of the article was a phone number for Broken Rites Australia. She rang the number and Broken Rites told her the priest who had abused her was under investigation by police, and encouraged her to come forward and make a statement, which she did.<sup>133</sup> Some research suggests that when faced with a legal problem some people turn to non-legal support services such as government or non-legal community groups rather than lawyers.<sup>134</sup> Research also suggests that advocacy and support may increase formal reporting of violence.<sup>135</sup>

We heard that some victims are concerned that once they report to police they will have no choice but to become involved in a criminal justice process that could include being the complainant in a prosecution. Other victims may be concerned that a police investigation could disrupt their lives and the lives of their families.<sup>136</sup> As we considered in our *Criminal justice* report, advocacy and support services play an important role in encouraging reporting by making information available to victims and survivors and their families about what will happen when they report to police: that their decision whether to participate in a police investigation will be respected; that they will retain the right to withdraw at any stage in the process; and that they may decline to proceed further with police or any prosecution if they wish.<sup>137</sup>

Advocacy can become crucial for victims with additional needs. We were told that advocacy tailored for people with cognitive impairments or complex communication needs can be important in assisting disclosure and subsequent reporting of sexual abuse.<sup>138</sup> The Victorian Ombudsman's investigation into the reporting of sexual abuse perpetrated against people with disability recognised the importance of advocacy in facilitating complaint handling and reporting of child sexual abuse.<sup>139</sup> The Ombudsman found that while advocacy is particularly important for those making complaints and reporting abuse, funding for advocacy services in Victoria was extremely limited. The Ombudsman recommended that funding for disability advocacy in Victoria be increased based on a comprehensive assessment of need.<sup>140</sup>



## 2.4 How therapeutic treatment assists victims and survivors

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This section describes what we have learned about how therapeutic treatment can assist victims and survivors of child sexual abuse.

Through our private sessions and consultation processes, we heard about many different therapies (sometimes called treatment modalities) being used to assist victims and survivors. Many survivors found therapeutic treatment helpful for responding to symptoms of trauma and assisting them on their journey of recovery, while others had varied or unhelpful experiences.

We were interested in what is known about effective therapeutic treatment for child and adult victims and survivors of child sexual abuse in institutional contexts. To understand which treatments are effective and how they work, we considered the perspectives of many victims and survivors and a range of practitioners, as well as the current best available academic literature on the efficacy of therapeutic treatments for trauma associated with childhood sexual abuse.

### 2.4.1 Survivors' experiences of therapeutic treatment

We heard during our inquiry that survivors accessed a range of therapeutic treatments. These therapies were both short term and long term, and came in different forms, for example, counselling,<sup>141</sup> psychotherapy,<sup>142</sup> body therapies,<sup>143</sup> creative therapies,<sup>144</sup> therapeutic groups<sup>145</sup> and psychiatric care, including prescribed medications.<sup>146</sup>

Many survivors told us they found therapeutic treatment helpful for managing relationships and the symptoms associated with trauma. 'Alexa' told us she was sexually abused by a primary school teacher and self-medicated with alcohol and heroin.<sup>147</sup> After several mental health professionals did not believe her disclosures, she told us she had a transformative experience of therapy in a rehabilitation clinic.

That's where I had a psychotherapist, he's the man who changed my life because he's the first person who believed me and he told my family that it was true as well ... His parting words to me were, 'This is the beginning'. And he was right. I never touched drugs ever again.<sup>148</sup>

Like 'Alexa', 'Marcia' told us that her experiences of abuse led to ongoing mental health problems including self-harming and eating disorders.<sup>149</sup> She told us, 'I got a lot of strength through the therapy and my doctor – if it wasn't for them I don't think I would have made it'.<sup>150</sup> Another survivor said that she 'learned a lot' from therapy. 'It wasn't just psychotherapy,

I learned strategy, I learned mindfulness, things like that.’<sup>151</sup> In a private session, ‘Dean Clark’ told us that he did not consciously remember the abuse for decades after it had occurred, but that he found therapy helpful as he began to recall the details.<sup>152</sup> He told us that, during therapy, he sometimes regresses to the age he was when the abuse occurred:

I’m eight years old. I want to sit on the therapist’s lap, curl up and bury my head in his chest ... The times when I’ve been in that space and he’s managed to match it with a response suitable for an eight-year-old are the ones that have helped me the most.<sup>153</sup>

We also heard from survivors who had poor or mixed experiences of treatment. Survivors identified issues in obtaining information about the training and experience of practitioners, as well as identifying the most appropriate treatment for their situation. ‘Noreen’ told us that she didn’t find counselling to be helpful.<sup>154</sup> ‘I felt it didn’t really work. [The counsellor] kept referring to the Dalai Lama. And a lot of the things she said to me were gobbledygook.’<sup>155</sup> Similarly, ‘Myra’ told us that she often found interactions with mental health professionals to be traumatic:

I am yet to have an encounter with a mental health worker, ie nurse, social worker, psychologist, that hasn’t included being told ‘no one is going to touch you’ only for them to eventually lean over and do exactly that ... I appreciate the intention may be comfort or consolation however the impact for me is re-traumatisation; having my bodily integrity compromised by someone else’s needs or desires over my own.<sup>156</sup>

Many survivors told us that medication was an important aspect of their treatment. We were often told that medication helped to stabilise symptoms and assist survivors to build resilience.<sup>157</sup> For example, ‘Griff’ told us that medication has helped him cope with the impact of anxiety attacks.<sup>158</sup>

However, some survivors told us that medication did not address the underlying issues they were facing.<sup>159</sup> ‘Richie’ told us that he is on medication for depression, but believes his mental health situation might be more complex.<sup>160</sup> ‘Isabel’ said she was prescribed sleeping pills after disclosing the abuse to doctors.<sup>161</sup> She told us that, ‘you can give me as much medication as you like but it’s not going to help’.<sup>162</sup> ‘Dina’ told us that, when she has tried to speak to doctors about her needs, ‘All they want to do is stuff you with pills’.<sup>163</sup>

There are consequences for receiving poor or ineffective treatment. For children who have experienced sexual abuse, there is a risk that poor treatment will result in chronic symptoms that follow them into adulthood<sup>164</sup> and make them more vulnerable to further victimisation over their lives.<sup>165</sup> We also heard that inappropriate or ineffective treatment may lead adult survivors to blame themselves for treatment ‘failure’ or see themselves as broken and unable to recover. Ineffective treatment can undermine recovery if victims lose hope and disengage from support systems.

## 2.4.2 Understanding the effectiveness of therapeutic treatment

Understanding which therapeutic treatments are effective for which victims and survivors is not straightforward, for several reasons. First, the study of trauma arising from child sexual abuse is relatively recent, as is the application of different therapeutic approaches. Practice is developing and while there is a large body of evidence about a few established treatments, there are emerging treatments that have not been systematically evaluated.

Second, while we use the term ‘treatment’, sexual abuse is not a disease or medical condition. Rather, it is an adverse life event or series of adverse life events.<sup>166</sup> What is being ‘treated’ in a clinical sense is a variety of distressing or disabling symptoms that arise from, or are adaptations to, psychological trauma. As Volume 3, *Impacts* notes, there is a strong association between experiencing sexual abuse in childhood and subsequent symptoms in both childhood<sup>167</sup> and adulthood.<sup>168</sup> These symptoms include diagnosable mental health disorders, as well as interpersonal issues such as trust. Different treatments may be effective in addressing particular symptoms, and these do not necessarily address the underlying trauma, which may require additional intervention.

Third, the clinical and empirical literature increasingly suggests that post-traumatic stress disorder (PTSD) does not reflect the full range of symptoms that survivors of child sexual abuse may experience.<sup>169</sup> Therapeutic treatments have traditionally targeted symptoms associated with PTSD, such as: ‘re-experiencing’ and ‘intrusion’ (sometimes experienced as flashbacks); avoidance and ‘numbing’; hyper-vigilance, anxiety, depressive symptoms and disorders; and somatic symptoms.<sup>170</sup> However, children abused within relationships of care, dependence or authority also face neurological and developmental consequences for their evolving personality and capacity for healthy attachment.<sup>171</sup> Furthermore, shame plays a significant role in the experience of trauma related to child sexual abuse<sup>172</sup> and this adds dimensions of self-blame and humiliation to the injury.<sup>173</sup> In addition to addressing symptoms of PTSD such as fear, hyper-vigilance and hyper-arousal, therapeutic treatment may need to respond to these developmental and interpersonal impacts. These impacts include the person’s capacity to form trusting relationships, disrupted or disorganised attachment, altered self-perception, changes in affect regulation, guilt and shame.<sup>174</sup>

Fourth, the established approach to evaluating the effectiveness of treatment is to ask whether there is a reduction in the symptoms associated with trauma. Symptom reduction plays an important role in healing or recovery from trauma, but may not alone meet many survivors’ needs. In addition to symptom reduction or symptom management, healing or recovery may include ‘increasing protective factors, such as self-esteem, social support, relationships and related skills’,<sup>175</sup> recognising survivors’ strength and resilience<sup>176</sup> and promoting experiences of post-traumatic growth.<sup>177</sup> Other elements of recovery may include: restorative justice; opportunities to overcome loss, isolation or shame through group work;<sup>178</sup> and empowerment through participation in collective action.

Fifth, just as there are significant points in life that can be turning points for recovery,<sup>179</sup> there may also be times when victims and survivors have greater need for therapeutic support.<sup>180</sup> Qualitative research has identified trigger points associated with higher support needs, including intrusive medical procedures,<sup>181</sup> issues associated with parenthood for both men and women,<sup>182</sup> and a survivor's own child being abused.<sup>183</sup> The ageing process itself may complicate symptoms arising from childhood trauma and present new challenges for treatment where there is a decline in expression, perception and memory.<sup>184</sup> This is consistent with what we have learned through private sessions and has implications for how we understand the type, timing, intensity and duration of therapeutic interventions.

Finally, while Section 2.4 discusses the literature on the efficacy of distinct treatments, we know many practitioners use a range of different approaches depending on the individual client and where they are in the process of recovery. A treatment that is effective for a client experiencing anxiety may be inappropriate or even harmful for another client. Given the interpersonal nature of child sexual abuse and its subsequent impact on attachment relationships, it is also likely that careful attention to the therapeutic relationship in conjunction with an evidence-informed approach is important, regardless of the specific treatment type.<sup>185</sup>

In Section 2.5 we outline what we learned from victims, survivors, practitioners and a growing research base about broader perspectives of healing and recovery from trauma associated with child sexual abuse.

### 2.4.3 The current state of knowledge

The research investigating what therapeutic treatment is effective for victims of child sexual abuse falls into two categories: 'instrumental' knowledge and 'conceptual' knowledge. Instrumental knowledge is produced through empirical investigation measuring or comparing the efficacy of different forms of practice. This knowledge is governed by the technical rules of the scientific method. Evidence informing instrumental knowledge is broken down into a hierarchy based on the type of method and rigour employed. At the top of the evidence hierarchy are:

- systematic reviews and meta-analyses<sup>186</sup>
- randomised control trials<sup>187</sup>
- quasi-experimental methods.<sup>188</sup>

Even the best quality instrumental knowledge that considers therapeutic treatment has limits. For this reason we also investigated the available conceptual knowledge regarding effective practice. Conceptual knowledge is based on emerging research about neuroscience and the impact of trauma on brain functioning. This research is currently emerging and its implications for practice have not yet been rigorously investigated. However, this research is likely to inform studies in the future.<sup>189</sup>

## Instrumental knowledge

There is a substantial body of literature on the evaluation of various models of therapeutic treatment. This literature is of variable quality.<sup>190</sup> To assist in our understanding of this evidence, we commissioned a review of the available research on what works for both child and adult victims and survivors of child sexual abuse.<sup>191</sup> The review found evidence for the effectiveness of cognitive behavioural therapy (CBT) for adult survivors of child sexual abuse in certain circumstances. In particular, CBT showed large and substantial clinical gains for adult survivors who were experiencing trauma-related and internalising symptoms, such as depression or anxiety.<sup>192</sup>

The review also found that trauma-focused CBT (TF-CBT) had the best available evidence of treatment effectiveness for child victims of sexual abuse, with large and substantial reductions in trauma-related and internalising symptoms.<sup>193</sup> TF-CBT is a model of psychotherapy that addresses the aftermath of traumatic events, incorporating exposure, cognitive processing and reframing, stress management and parental treatment.<sup>194</sup> The evidence, however, suggests CBT may not be as effective for children with substantial and disruptive behavioural issues, such as substantial externalising problems and persistent sexualised behaviour.<sup>195</sup> Therapeutic interventions for children with harmful sexual behaviours is discussed further in Volume 10, *Children with harmful sexual behaviours*.

While the review identified other promising approaches – in particular eye movement desensitisation and reprocessing (EMDR) – the authors concluded that there is a need for more high-quality evidence of the effectiveness of therapeutic interventions with victims and survivors of child sexual abuse.<sup>196</sup>

We understand from this that, in the available evaluations of treatments for victims and survivors of child sexual abuse, the best evidence to date has found that CBT for adults and TF-CBT for children are the most effective treatments for reducing specific, internalising symptoms. These findings do not suggest that every person who receives CBT will improve, nor that they will necessarily recover from other impacts of childhood sexual abuse. It means the best available instrumental knowledge shows that, on average, more people will improve than would have done so with no treatment or with a different approach.<sup>197</sup>

## Limitations and future directions for the instrumental knowledge base

While the literature is strongly supportive of CBT and TF-CBT as effective in reducing some symptoms related to trauma, we would exercise caution in recommending these approaches as best practice for victims and survivors of child sexual abuse for several reasons. First, the outcomes measured in the literature tend to be short term, with much less known regarding long-term outcomes of both CBT and other treatment modalities. Second, there is a gap in knowledge about the efficacy of other therapeutic techniques, such as psychodynamic therapy, for victims and survivors of child sexual abuse. This means that other treatment modalities may be viable, but have not been rigorously tested.<sup>198</sup> Finally, many of the outcomes measured in the research literature relate to a reduction in symptoms rather than long-term recovery, which is more subjective and difficult to measure.<sup>199</sup> While CBT has been found to be effective in reducing a range of symptoms, less is known about its comparative efficacy in promoting recovery.

There is also concern among trauma researchers and practitioners that clinical efficacy studies of PTSD treatment screen out participants with concurrent conditions and some of the complex symptoms associated with child sexual abuse.<sup>200</sup> Highly controlled efficacy studies often require that the issue being treated is occurring in isolation. For example, a victim or survivor who experiences anxiety symptoms and also has a serious substance use disorder may be ineligible for participation in a study. The results of the study may then not be applicable to the many victims and survivors who experience these co-occurring conditions. More effectiveness studies (those that test the intervention in real settings) are required to establish how the treatment would work in less controlled settings among diverse populations. Priority should be given to methods that target sub-populations that have previously been excluded from evaluations.<sup>201</sup>

Our commissioned review suggested that, for both adults and children, gains from CBT tended to be maintained over the short and medium term, but showed some diminution over time.<sup>202</sup> Given that recovery from trauma is likely to be dynamic and that old age may present therapeutic challenges, further research is needed to know how effective treatments and combinations of treatments would be for survivors over the life course.

Studies examining the needs of certain groups of survivors are another gap in the evidence. Most studies examine the experiences of female survivors of child sexual abuse and the findings are not necessarily transferable to men.<sup>203</sup> Similarly, very little research is available on outcomes for culturally and linguistically diverse groups, Aboriginal and Torres Strait Islander people or survivors who are gender diverse. Further research is needed to understand the effectiveness of treatments for these groups.

There is a much broader literature that examines the effectiveness of therapeutic treatment for overlapping client populations. For example, we know that there is an over-representation of borderline personality disorder among survivors of child sexual abuse<sup>204</sup> and there is high-quality evidence that dialectical behavioural therapy (DBT) is effective in reducing some symptoms associated with the disorder.<sup>205</sup> However, this research does not specifically indicate whether DBT is helpful for survivors of child sexual abuse who have been diagnosed with borderline personality disorder. Research should examine whether other therapeutic treatments are effective for victims and survivors of child sexual abuse.

## Conceptual knowledge

There are several emerging models of therapeutic practice based on developments in neuroscience and attachment theory. Because these innovative approaches have not been systematically evaluated, they are not part of the instrumental body of knowledge. Rather, they are based on emerging conceptual knowledge, particularly in the fields of interpersonal neurobiology, affective neuroscience and neurobiology of attachment. They are likely to inform developments in the instrumental knowledge base in the future. While therapeutic approaches can be informed by emerging conceptual knowledge, it is very important that they are systematically evaluated to contribute to the instrumental knowledge base.

We learned that developments in neuroscience (interpersonal neurobiology, affective neuroscience, neurobiology of attachment) and parallel developments in attachment theory are being applied to innovations in therapeutic treatment approaches.

Recent advances in technology have enabled researchers to conduct the first neuroimaging studies of trauma and the processing of intense emotions.<sup>206</sup> These neuroimaging studies have progressed our understanding of the changes that occur in the brain that are believed to be responsible for physical and psychological symptoms associated with complex trauma, such as difficulties in regulating emotional and physiological states and communicating experiences in therapeutic settings:

Exposed to traumatic reminders, subjects had cerebral blood flow increases in the right medial orbitofrontal cortex, insula, amygdala, and anterior temporal pole, and a relative deactivation in the left anterior prefrontal cortex, specifically in Broca's area, the expressive speech center in the brain, the area necessary to communicate what one is thinking and feeling ... when people are reminded of personal trauma they activate brain regions that support intense emotions, while decreasing activity of brain structures involved in the inhibition of emotions and the translation of experience into communicable language.<sup>207</sup>

The advancement in neuroscience supports earlier theories of complex trauma that trace back to the 1970s.<sup>208</sup> When abuse occurs in childhood, social, emotional and cognitive capacities are in sensitive stages of development. This can result in the ‘disruption of the emergent capacity for psychobiological self-regulation and secure attachment’.<sup>209</sup>

Understandings of attachment have also provided insights into the impact of trauma and, by extension, treatment approaches that might prove effective. Secure attachment in a child’s early life forms the basis of a child’s ability to regulate emotions and to respond to situations with flexibility.<sup>210</sup> This confirms what psychiatrist Professor Judith Herman has described as permitting the ‘development of a self-identity as a person worthy of love and care and a capacity to love and care for others’.<sup>211</sup> As discussed in Volume 3, *Impacts*, children who are soothed and comforted when they experience distress gradually learn to comfort themselves and regulate their emotions.<sup>212</sup> When attachment is disrupted, for example, when a child is abused by a carer or when a carer neglects to protect them from abuse, this may have a developmental and neurobiological impact on the child’s ability to regulate emotion and learn about themselves and others.<sup>213</sup>

Neuroplasticity research suggests that neural pathways have the potential to be reorganised by experiences, relationships and therapy and are not fixed as was previously thought.<sup>214</sup> While neuroscience shows us that repeated or prolonged exposure to trauma in childhood negatively affects the developing brain, neuroplasticity research offers the possibility of reparative change by supporting activity that creates new neural pathways in the brain.<sup>215</sup> Approaches to treatment based on this conceptual knowledge are explored in the academic literature,<sup>216</sup> but have not been systematically evaluated for effectiveness in reducing the symptoms of unspecified complex trauma or child sexual abuse.

## Implications for treatment

The emerging conceptual knowledge challenges the appropriateness of established treatments for complex trauma. Treatments that rely solely on a person’s cognitive capacities (such as CBT) may not always be effective for victims and survivors of child sexual abuse presenting with symptoms of complex trauma.<sup>217</sup> Likewise, neuroscience has also led some practitioners to reappraise the appropriateness of interventions that seek resolution via verbal expression of trauma alone (talk therapies or general counselling), when the act of trying to recall experiences of abuse may overwhelm the survivor to such an extent that they are unable to translate these experiences into words.<sup>218</sup>



For approaches based on emerging conceptual knowledge, the emphasis is on resolving ‘the repetitive, unbidden physical sensations, movement inhibitions, and somatosensory intrusions characteristic of unresolved trauma’.<sup>219</sup> The theory of change that underpins these approaches is that the ‘bottom-up processing approach of experiential therapies’ works by ‘activating emotional processes through techniques that focus on sensory, somatic and motoric experience’ instead of cognitive processes like narrating, interpreting or analysing their experience.<sup>220</sup> Some small-scale studies suggest that victims and survivors may benefit from appropriately modified adjunct therapies, such as mindfulness or body-based therapies, to help them tolerate sensations associated with remembering the abuse or to maintain treatment gains by improving emotional regulation and the capacity to better recognise sensations of safety and danger.<sup>221</sup>

These approaches to treating complex trauma are in development and have not been systematically evaluated. In principle, therapeutic treatments should be based on valid conceptual knowledge about trauma, including complex and intergenerational trauma. They should include a clearly identifiable, articulated and legitimate theory of change; that is, a theoretically informed mechanism by which symptoms are being addressed. In the longer term, funding is required to ensure that emerging approaches informed by conceptual knowledge are rigorously evaluated for effectiveness and can contribute to the established instrumental evidence base.

Regardless of the particular treatment modality used, safe therapeutic relationships are critical for healing and recovery. In our *Nature, cause and impact of child sexual abuse* case study, we heard from a number of practitioners about the importance of trust in therapeutic relationships. Dr Marshall Watson, a child and adolescent forensic psychiatrist, told us:

one of the big issues that we see is issues of trust or mistrust and that can certainly impact upon therapy, because we’re all relational beings and when people have been a victim of abuse, one of the big issues is certainly a breach of trust.<sup>222</sup>

Child and adolescent psychiatrist Dr Bruce Perry concurred:

everything that we learn, the entire way we heal, is all in the context of relationships, and if the very vehicle that we use to learn, to grow, to develop, to heal, to engage, to teach – all the stuff that we do as a parent – if that is corrupted by the process of sexual abuse and you can’t trust and you don’t feel safe, it makes it difficult for you to make your way through life.<sup>223</sup>

Section 2.5 elaborates on the importance of trust, safety and empowerment to promote healing and recovery in therapeutic treatment services.

## 2.5 Service system principles for healing and recovery

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This chapter has described how advocacy and support and therapeutic treatment can assist victims and survivors to cope with the impacts of institutional child sexual abuse. This section outlines key principles to underpin a service system that is responsive to the needs of victims and survivors. By 'service system' we include not only direct service providers, but also legislative and policy frameworks, funding arrangements, professional education and codes of conduct that guide advocacy and support and therapeutic treatment responses to survivors.

Healing and recovery are different for everyone, influenced by family and community relationships, cultural contexts, history, gender, age and personal characteristics. Healing and recovery should not only focus on alleviation of symptoms, but also support broader health and wellbeing. As one survivor told us:

I find it hard to think about future support needs without considering the need for healing and access to opportunities to facilitate that. It is one thing to be supported and have access to therapeutic services that are mostly mind based and time limited. It is another thing to be transformed from the trauma of abuse and to move on from it to a different and better way of being.<sup>224</sup>

No single program can provide all the types and levels of support that would be required for healing and recovery. Victims and survivors need a holistic service response that addresses all aspects of their wellbeing, which may include financial, legal, medical, psychological, spiritual and other forms of assistance.

We heard from many thousands of people in private sessions and through written accounts, as well as from professionals through our consultation processes, about service approaches that promote healing and recovery. Using this knowledge and a growing research evidence base we have developed a set of guiding principles for a service system that is responsive to children and adults who have experienced childhood sexual abuse. These principles are consistent with our recommended principles for a redress scheme and add detail relevant to the broader scope of our work on advocacy and support and therapeutic treatment.<sup>225</sup>

First, a responsive service system should be **trauma-informed and have an understanding of institutional child sexual abuse**. This has different implications for different services, but all parts of the service system should have an understanding of trauma-informed practice, appropriate to their role.

This foundational principle informs subsequent principles for a responsive system, in which services are:

- **collaborative.** Because of the complexity of the service system and breadth of potential needs, it is important for services to collaborate to help victims and survivors find their way to the right service at the right time. Collaborative practice increases pathways to support and enhances professional coordination. This would minimise the need for a victim or survivor to retell their story multiple times
- **available** in sufficient quantity and at the appropriate time and place to respond to victims' and survivors' needs. Services should be flexible and have the capacity to provide support for the period required by the survivor. Individuals should be able to access services they need, and should not be excluded without a supportive referral to another agency
- **accessible** for all victims and survivors. Services should be affordable or free at the point of delivery. They should make use of technology and outreach to ensure access for people in regional and remote areas. Services should not present barriers to people with mobility and communication impairments, and should provide accessible information
- **acceptable** by responding to lived, social and cultural contexts of victims and survivors. Staff should have the skills and capability to respond effectively to diverse needs, or collaborate with other agencies to meet those needs
- **high-quality.** Services should be evidence-informed, with a trained and informed workforce and be subject to ongoing evaluation
- **inclusive of Aboriginal and Torres Strait Islander healing approaches.** Acknowledging the unique, historical context of the Stolen Generations and the common experience of childhood institutionalisation for many Aboriginal and Torres Strait Islander people, there is a need for culturally safe and effective responses for Aboriginal and Torres Strait Islander survivors. We have heard in many submissions and consultations that Aboriginal and Torres Strait Islander healing approaches are an important part of the service system, in addition to culturally responsive mainstream services.

The following section expands on each of the service system principles. While parts of the service system already operate in accordance with these principles, we learned that they have not always been applied.

### 2.5.1 Understanding institutional child sexual abuse and working with trauma

To provide effective services that avoid re-traumatisation, it is essential to have an understanding of the effects of trauma associated with institutional child sexual abuse. It is important that advocacy and support and therapeutic treatment services foster safety, build trust, seek to empower victims and survivors, and validate their experiences.

Service systems should also be responsive to the impact of childhood trauma on a person's health and wellbeing throughout their life. We are of the view that service systems should be trauma-informed and equipped to respond effectively to the different needs of victims and survivors as children, young people, adults and in older age.

#### Safety, empowerment and validation in advocacy and support and therapeutic treatment services

Because child sexual abuse compromises the safety of the victim, a priority for services responding to children and adults who have experienced childhood sexual abuse should be to establish safety. This is recognised in existing literature<sup>226</sup> and in guidelines on how to respond to complex trauma.<sup>227</sup> We have heard from a number of different front-line agencies in the government and non-government sectors about the importance of establishing safety and building trust in their practice.<sup>228</sup> In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, the South Australian Government, drawing on its experience in delivering and managing a range of services for victims and survivors, said that safety and building trust are key to healing and long-term recovery.<sup>229</sup> Commissioned research supports this, noting that services should ensure that their 'organisational, operational and direct service-provision practices and procedures promote, not undermine, the physical, psychological and emotional safety of consumers and survivors'.<sup>230</sup>

One survivor, 'Amos', described the importance of trust in the recovery process for dealing with prior trauma and the resultant difficulties he faced.<sup>231</sup> 'Amos' had a good rehabilitation experience, during which he met a counsellor he immediately felt he could trust. 'She worked tirelessly with me, she worked hard with me ... And I thought, you know, if I ever want to get better, and give up this heroin, I better get to the core of these abuse issues.'<sup>232</sup>

We have also consistently been told that engaging with services should be empowering for victims and survivors. Empowerment is important in the recovery process, as it helps individuals regain and develop the strengths and skills necessary to more directly address the trauma of past child sexual abuse and its impacts.<sup>233</sup> Victims and survivors can be empowered by being actively involved in their own therapy<sup>234</sup> and being given the opportunity to make informed

choices about the treatment and support they receive.<sup>235</sup> We were told that services should actively seek and encourage client feedback, and implement this feedback into practice where appropriate.<sup>236</sup> Services should be provided in circumstances in which victims and survivors are empowered to make informed choices based on best available knowledge.

Several agencies highlighted the importance of a customised or ‘person-centred’ approach.<sup>237</sup> Family Planning NSW told us that service providers need to work closely with victims and survivors to identify their specific needs, while being aware that people can present at different stages of recovery.<sup>238</sup> Queensland advocacy and support service Micah Projects emphasised the importance of a person-centred approach where the survivor is enabled to identify their needs, and the preferences of the individual and family are the focal point of the support and advocacy work. This helps to maximise choice, voice, empowerment, dignity and respect through the working relationship.<sup>239</sup>

We were told that it is important that victims and survivors are believed when disclosing abuse, that their experiences are validated and that they are not ignored or disrespected. In submissions to our *Advocacy and support and therapeutic treatment services* issues paper we were told that not being believed or taken seriously can be harmful for victims and survivors.<sup>240</sup> Commissioned research supports this, suggesting that victims and survivors need service providers that empower and advocate for them and validate their disclosures and experiences.<sup>241</sup> One survivor told the researchers of the power of validation: ‘Look, at the end of the day affirmation, we need this, this affirmation, this acceptance that we’re survivors, not this constant rejection and marginalisation and victimisation’.<sup>242</sup> Validation can help mediate trauma symptoms and support survivors to focus on healing.<sup>243</sup>

Ensuring that services foster safety, empower victims and survivors, and validate experiences of child sexual abuse requires a capable specialist workforce and a generalist service environment that is aware of the impact of trauma. Commissioned research concluded that, for agencies delivering targeted services to victims and survivors of child sexual abuse to be effective, the workforce should be knowledgeable about the broad history of institutional abuse, informed about populations who may present with this history and have the skills to assess and respond appropriately.<sup>244</sup> This research also noted that, because the ongoing impact of trauma is likely to result in victims and survivors of child sexual abuse accessing non-specialist support – such as mental health, alcohol and other drug, homelessness and family violence services – these generalist support services should also be aware of the history and context of institutional abuse.<sup>245</sup>

However, we have heard that there is currently limited understanding in the service system of the direct and indirect consequences of trauma. We have been told about the lack of understanding of child sexual abuse and trauma across human services, which we consider in Chapter 4, ‘Barriers to help-seeking and effective service responses’. To address these shortcomings, service systems should adopt a trauma-informed approach.

## Trauma-informed systems

The trauma-informed approach is a framework for service provision by which the practices, policies and culture of an organisation and its staff are responsive to the impacts of trauma on the wellbeing and behaviour of service users.<sup>246</sup> A trauma-informed service agency critically examines its own practice – from management to front-line delivery – to ensure that the organisation and its workers are meeting the needs of clients.

Trauma-informed practice is particularly important for victims and survivors of child sexual abuse, as service provision can mirror aspects of the institutional environment in which the abuse took place. For example, the relationship between a therapist and a client involves an inherent power imbalance and a degree of secrecy. This creates a risk that victims and survivors could be re-traumatised through the process of seeking support.

Many submissions from services, professional bodies and governments to our *Advocacy and support and therapeutic treatment services* issues paper identified trauma-informed care as an essential component in the safe and effective provision of advocacy and support and therapeutic treatment services.<sup>247</sup> In its submission to the issues paper, Family Planning NSW explained:

In all instances, it is important that service providers across the health and community spectrum ensure staff can provide trauma-informed care at all levels of service delivery, have policies in place to identify and appropriately manage risk factors and disclosures, and be aware of treatment and referral services available.<sup>248</sup>

State and territory governments informed us of growing interest in trauma-informed approaches in specific settings. Most governments informed us they had introduced, or were in the process of introducing, specific training on trauma-informed practice for staff in adult<sup>249</sup> and youth detention settings.<sup>250</sup> For example, the South Australian Department of Communities and Social Inclusion reviewed its Youth Justice policies and procedures, including staff training, through a trauma-informed lens to improve responses to children and young people who have experienced trauma.<sup>251</sup>

We commissioned a research project to examine the understanding and application of the trauma-informed approach in Australia and internationally. The project found that the concept of trauma-informed approaches to health, community and human services is of growing interest in Australia,<sup>252</sup> but is applied differently in different settings.<sup>253</sup> Despite this variation, the research identified the following key principles:<sup>254</sup>

- Practitioners should have a sound understanding of the prevalence and nature of trauma and its impacts on other areas of life and functioning.
- Organisational, operational and direct service provision practices and procedures should promote the physical, psychological and emotional safety of victims and survivors.
- Service cultures and practices should empower victims and survivors in their recovery, through autonomy, collaboration and strength-based approaches.
- Practitioners should recognise the lived, social and cultural contexts that shape victims' and survivors' needs, as well as their recovery and healing.
- Practitioners should recognise the relational nature of both trauma and healing.

A trauma-informed approach is systemic. It involves specialist and mainstream services and should be reflected in the actions of all client-facing staff at all levels of the service system.<sup>255</sup> This does not mean that all service providers must provide specialist trauma support, but rather that all service providers be sensitive and responsive to the ongoing impact of trauma on their clients. Adopting this approach involves training as well as strategic, organisational and procedural change.<sup>256</sup>

We are encouraged by promising examples of trauma-informed approaches in various sectors in Australia.<sup>257</sup> At this stage, however, there is only a limited body of research evaluating its implementation.<sup>258</sup> Within this context there is a risk that programs may become 'trauma-informed' in name only, using limited resources on initiatives of limited value. We recognise that a strategic, national approach to implementing trauma-informed care should include appropriate evaluation and access to the best available evidence.

We consider that the trauma-informed approach is closely aligned with the needs of victims and survivors of child sexual abuse. It is a relevant, appropriate and useful framework that could ensure that their needs are met. A trauma-informed approach with an embedded understanding of the dynamics and impacts of institutional child sexual abuse should be applied to the advocacy and support and therapeutic treatment service system.

## 2.5.2 Service collaboration

No single service or service system has the capacity to respond to all the needs of every victim and survivor of child sexual abuse in institutions. Many survivors engage with a range of service agencies during their life. This is especially the case for survivors with complex needs, who may engage with front-line agencies from a range of different service sectors. Many survivors told us that navigating the service system has itself been traumatic. As far as possible, this should not occur. To that end, some collaboration between services and service sectors is necessary in responding to victims and survivors, particularly those with complex needs.

Collaboration involves formal and informal relationships between programs, delivered by agencies or across agencies so that resources are shared or exchanged to achieve common goals.<sup>259</sup> Collaboration is referenced in some national frameworks that are relevant to the needs of survivors of child sexual abuse.<sup>260</sup> A collaborative service sector is particularly important for people who are dealing with trauma because coordinated assessment would remove the need for clients to retell their stories to each service provider, reducing the risk of re-traumatisation.<sup>261</sup>

Collaboration can help to address the fragmented nature of the service system and the diversity of needs, experiences and backgrounds of victims and survivors. It can promote sharing of knowledge and resources, and build the capacity of the service system as a whole to meet the full range of victims' and survivors' needs. Collaboration is particularly important for meeting the needs of victims and survivors from culturally and linguistically diverse backgrounds. Participants in the Royal Commission's multicultural forums agreed on the need to connect multicultural and ethno-specific services with mainstream and specialist sexual abuse support services.<sup>262</sup>

Services could collaborate in two ways. First, they could restructure their practice to integrate their services. This type of collaboration is generally management-led and can involve initiatives such as co-location or the use of standard intake procedures and referral processes. Second, services could coordinate or manage a client's transitions through the service system, tailoring the services offered to the client and involving additional agencies as required. These approaches to integration are described as 'structural' and 'individualised'. They share a common goal: to ensure that the victim or survivor is receiving the appropriate services and does not necessarily need to coordinate their own care.

## Structural approaches

While we have heard of structural problems with the service system that have caused re-traumatisation for victims and survivors, services could be restructured to foster positive outcomes.

Any entry into the service system should be considered as a possible referral pathway to the right service. This principle, sometimes called the 'no wrong door' approach, recognises that victims frequently present or disclose to service providers that are not well placed to respond appropriately.<sup>263</sup> Services to which child sexual abuse has been disclosed should not end their contact with the client until they are confident that the client is engaged with a service agency that is able to address their needs.<sup>264</sup>



Many models of collaboration seek to achieve the trauma-informed principle of preventing vulnerable victims from having to retell their stories to multiple service providers. For example, 'one-stop shop' service hubs, where services are co-located, allow staff from different agencies to communicate and build relationships.<sup>265</sup> We were told that this model can reduce the need for victims and survivors to navigate the service system themselves.<sup>266</sup> However, co-location and other models of collaboration are only tools to achieve a better service offering, not goals in themselves.<sup>267</sup>

Collaboration between services would take different forms, depending on the circumstances of the services. No single model would be effective in all circumstances, and efforts towards collaboration should be carefully considered by each agency. The Canberra Rape Crisis Centre told us that its clients require support from a range of services, but that this was frequently arranged informally by individual practitioners.<sup>268</sup> Other agencies told us that they saw benefit in memoranda of understanding and other formal agreements between agencies.<sup>269</sup> The goal of collaboration should always be to improve support for victims and survivors, while being mindful of their rights to privacy.

## Individualised approaches

Individualised approaches to collaboration can involve facilitating referrals, case management, advocating on behalf of clients and providing flexible support for ad hoc needs through brokerage funding.

We heard from service providers about the importance of supporting clients as they access different services. This could be through 'warm' referrals<sup>270</sup> in which, with the survivor's permission, one agency facilitates support from other agencies on behalf of the client to ensure continuity of support and avoid the client having to retell their story. In commissioned research, one service provider discussed the importance of warm referrals for clients who have recently disclosed abuse:

disclosing something like sexual abuse, especially if it's happening to a young person, at that time it's going to be upsetting. They're going to be very distressed, so really supporting [the individual] to link in to the next service. So not just handing them a bit of paper but giving them a phone call, calling together, walking them to the [next service] ... really understanding that if it's something distressing, not just saying, 'If you want extra help, there it is'. Actually ... walking beside them to facilitate them accessing support services.<sup>271</sup>

Several services working with survivors discussed the importance of case management in addressing the needs of survivors who have engaged with different providers.<sup>272</sup> Case management offers intensive support and advocacy in relation to housing, education and training, employment, financial advice, healthcare and other needs that are beyond the scope of counselling.<sup>273</sup> Anglicare WA said that case management should support victims and survivors to identify and contact resources for themselves, and gain independence.<sup>274</sup> We were also told that therapeutic case management is essential to any therapeutic involvement with a family.<sup>275</sup>

One advocacy organisation preferred to use the term ‘planned support’ instead of case management, in recognition that many victims know what they need and want, and that the role of the agency is not to manage clients, but to listen to them, support them and work alongside them.<sup>276</sup> In commissioned research, practitioners advised that clients should retain ultimate control of case management to prevent further disempowerment and traumatisation.<sup>277</sup>

Some services preferred a counsellor/advocate model for supporting victims and survivors who have additional needs. In this model, practitioners provide both therapeutic support and advocacy as well as community education and training.<sup>278</sup> The Gippsland Centre Against Sexual Assault told us that, in its view, the counsellor/advocate model can reduce the time that victims and survivors require support from services.<sup>279</sup>

Non-government services told us that they used brokerage funding to assist victims access additional services, particularly in times of crisis.<sup>280</sup> Brokerage funding is untied funding for ad hoc purchases of goods and services. Some services told us about the need for brokerage to meet the emergency needs of victims and survivors, such as clothing, accommodation, food and healthcare.<sup>281</sup> It is also used to purchase services outside the funded system, which may include allied health services<sup>282</sup> or additional services in regional or remote areas.<sup>283</sup> Some funding agreements include brokerage components because agencies may need to meet practical needs before effective therapy can take place.<sup>284</sup> We were told that brokerage funding is an important means by which many services respond to their clients’ practical needs, which might otherwise prevent them from accessing appropriate support.<sup>285</sup>

Some agencies told us that their practice frequently involved outsourcing to other services as appropriate for their clients.<sup>286</sup> In a submission to our *Advocacy and support and therapeutic treatment services* issues paper, the Care Leavers Australasia Network told us of the importance of brokerage funding in meeting survivors’ needs:

It is important for all services to understand that not every Care Leaver wants counselling (which most services offer) but may feel they can get more use out of other options like brokerage funding for allied health services.<sup>287</sup>

### 2.5.3 Availability, accessibility, acceptability and high quality

The International Covenant on Economic, Social and Cultural Rights, ratified by Australia in 1975, enshrines the right to the highest attainable health.<sup>288</sup> This right involves four essential elements for the delivery of services: availability, accessibility, acceptability and quality.<sup>289</sup> We adopted these four elements to frame the information we considered about promising practices in delivering services that respond to the needs of victims and survivors. Achieving the four elements would involve service and funding contexts that are sensitive to the impacts of institutional child sexual abuse, how trauma may manifest in each person and the dynamics of recovery.

#### Availability

Services should be available to victims and survivors throughout their lives and for as long as needed. For some people, this may mean long-term advocacy and support and therapeutic treatment. Services should be flexible and responsive to needs that may change with key events or triggers, for example, when victims and survivors disclose abuse. The service system should build in the opportunity for victims and survivors to select the advocacy and support and therapeutic treatments they want to use.

We heard that services should be able to engage with victims and survivors over the long term. Through Medicare, survivors are able to access a total of 10 individual allied mental health sessions per year. In private sessions, survivors told us that this was helpful, but insufficient.<sup>290</sup> In a submission to our *Advocacy and support and therapeutic treatment services* issues paper, one survivor described the impact of this policy:

Only 10 hours Government approved counselling per year. As childhood abuse survivors that is nowhere near enough sessions per year. That's only one session every 5 weeks or so ... By the time you go back for your next session you are back to before because survivors need more regular sessions.<sup>291</sup>

Some services offer only short-term therapeutic interventions when survivors need ongoing counselling.<sup>292</sup> Many submissions to our *Advocacy and support and therapeutic treatment services* issues paper said that counselling sessions should not be limited.<sup>293</sup> Ongoing counselling is particularly important for survivors experiencing complex trauma.<sup>294</sup> For example, sexual assault services told us that many survivors need a long time to establish a sense of safety in their therapeutic relationship.<sup>295</sup> These services advocated for access to therapy over the long term to address the complex impacts of trauma.<sup>296</sup>

Survivors can be reluctant to seek assistance that is not ongoing. Research we commissioned included the responses of one survivor who received counselling through a redress process, but described being hesitant to engage in the therapeutic process without ongoing support:

I started having sessions with [a psychologist]. That went OK. But in my head I was thinking, 'Five sessions. I better not get too ... sort of emotional because I didn't want to bring myself undone'. By that stage I was actually quite depressed.<sup>297</sup>

We also heard that victims and survivors need flexible and adaptable services.<sup>298</sup> They can face a range of emotions and barriers when seeking assistance, and services should be responsive to this. For example, a survivor may reschedule an appointment several times before they are ready to attend.<sup>299</sup> We also heard that services should be responsive when individuals need to return to support services, for example, during crises or when symptoms are triggered.<sup>300</sup> In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, the Blue Knot Foundation said that flexibility and responsiveness in the service system would be enhanced through providing 'ongoing, affordable services which are trauma-informed and which offer appropriate support at any period during the life cycle'.<sup>301</sup> Commissioned research that assessed the views of parents and carers on accessing services found that the service's level of flexibility was one of the most commonly indicated factors that resulted in easier access.<sup>302</sup>

A service system that gives victims and survivors the choice of a range of services is important for recovery. As noted, no single approach works for everyone. Survivors should be able to try a range of services to find what suits them best. Several services told us that a range of advocacy and support and therapeutic treatments should be available<sup>303</sup> so that victims and survivors can choose: treatment modalities;<sup>304</sup> whether they engage face-to-face, by telephone or online;<sup>305</sup> and the length of time for which they engage.<sup>306</sup> A range of services should be available to respond in line with the nature and intensity of an individual's support needs. The Royal Australian and New Zealand College of Psychiatrists told us that a spectrum of support should be available for traumatised children and their families – from primary care, to integrated child and adolescent mental health services, to highly specialised inpatient care for those with the most acute mental ill health.<sup>307</sup>

A range of services is also essential to address the various ways in which trauma may manifest in an individual. For example, a survivor may seek specific treatments – such as CBT or psychodynamic therapies – or adopt adjunct therapies in combination with established modalities – such as body-based and regulatory approaches to address the neurobiological impacts of abuse. Given sexual abuse in childhood may have a negative impact on attachment relationships, a victim or survivor may need access to specific attachment therapies. Therapeutic group work may also be important for helping to build trust and to overcome feelings of shame or isolation.

Acknowledging the institutional contexts in which child sexual abuse occurred, agencies told us that where possible survivors should be free to choose their service provider and change providers.<sup>308</sup> For example, the Child Migrants Trust – a support service for the Former Child Migrants deported from Britain and their families – argued that for child migrants who experienced child sexual abuse, independence from agencies involved in child migration was important, as it provided therapeutic safety and helped develop trust and confidence.<sup>309</sup> For some survivors, it is important that the institution in which the abuse occurred is involved in providing support in some way. Some survivors who told us they were abused in religious institutions have sought to reconnect with their faith as part of healing and recovery.<sup>310</sup> For example, ‘Astrid’ told us in a private session that, although she said she was abused by a Catholic priest as a child, she has moved back to Catholicism ‘on my own terms’.<sup>311</sup> One service provider discussed the need to recognise, understand, nurture and address spiritual and religious needs.<sup>312</sup> It should be noted that choice between providers is not always possible, particularly when survivors are in institutional contexts such as psychiatric hospitals and detention facilities. Where choice is not possible, service providers should be particularly sensitive to their clients’ range of needs.

A trauma-informed service system assumes that any client could have a history of trauma and should be supported accordingly, allowing victims and survivors to receive the assistance they need whether or not they choose to disclose their experience of child sexual abuse. In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, The Women’s Cottage said that services need to provide options that do not require the disclosure of child sexual abuse – for example, drop-in support and skills development programs.<sup>313</sup> We also heard that, should survivors choose to disclose, it is essential to empower them as to when and what they disclose.<sup>314</sup>

## Accessibility

Services for victims and survivors of child sexual abuse should be accessible to all victims and survivors without discrimination. An accessible service system is physically and geographically accessible, meets victims’ and survivors’ information and communication needs, and is affordable.

Safe physical spaces are an important consideration for services that work with victims and survivors. A range of agencies told us that services should provide a secure, welcoming environment.<sup>315</sup> In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, the Western Region Centre Against Sexual Assault in Melbourne reflected on its clients’ feedback about ‘the therapeutic benefits of a warm, inviting, non-clinical (non-hospital/institutional-like) setting and a first contact experience that is friendly, informal and personalised’.<sup>316</sup> It is also important that services consider the accessibility needs of all victims and survivors, including people with physical disability.<sup>317</sup>

Accessibility also considers the geographic locations of victims and survivors. Submissions to the *Advocacy and support and therapeutic treatment services* issues paper noted that outreach support – by which specialists in metropolitan areas travel to smaller regional and remote communities – can help overcome issues of geographical availability.<sup>318</sup> In such cases, outreach sessions should be held in a venue that does not easily identify why the client is there, for example, in the offices of the local council, Centrelink or community health centre.<sup>319</sup> In its submission to the issues paper, Anglicare WA noted that regular and robust funding for consistent outreach was required to provide therapeutic treatment to victims and survivors of sexual abuse in regional and remote areas. It also said that support models need to address the potential additional costs of accessing supports in regional and remote areas, particularly travel costs.<sup>320</sup>

We heard that technologies such as video chat, teleconferencing and mobile apps can be effective in overcoming barriers to service accessibility caused by geographical distance.<sup>321</sup> In its submission to the *Advocacy and support and therapeutic treatment services* issues paper, Children with Disability Australia recommended increased resourcing and improved links with the information and communication technology (ICT) sector to increase the availability and accessibility of advocacy and support and therapeutic treatment services in regional and remote areas.<sup>322</sup> We heard that mobile phone text messaging systems that enable clients to give near real-time communication about their wellbeing, coupled with call-back systems, may be useful for those clients who benefit from immediate contact at times.<sup>323</sup> In its submission to the issues paper, Tasmanian sexual assault support service Laurel House said that the use of technology such as video chat and tablets is ‘nearly as good as face to face contact and certainly much better than phone support’.<sup>324</sup>

In another submission to the issues paper, People with Disability Australia said that many survivors of child sexual abuse may require extra communication support, and that this can be because of developmental delays associated with the impacts of trauma or pre-existing impairments, or a combination of both. They noted that the inadequate communication supports that are currently available can ‘impede general communication, recovery from trauma, and can put people at a heightened risk of repeated violence’.<sup>325</sup> This is consistent with the findings of a review of research into this area we commissioned, which noted that there were barriers for victims with intellectual disability to accessing appropriate services.<sup>326</sup> People with Disability Australia went on to describe the unmet need for necessary adjustments and the limited use of alternative communication techniques and technologies in the service system:

Many services also insist on providing their service with no adjustment or flexibility to respond to the specific needs of a person with disability, such as having shorter counselling sessions for people with intellectual disability, or utilising non-conversation-based psychological therapy for people with limited communication. For non-psychological as well as psychological support services, there is often very limited awareness of alternative or augmentative communication techniques and technologies. This can mean that people with disability are simply excluded from accessing the service.<sup>327</sup>

We were told that, within a complex service system, victims and survivors need clear information about what services are available and what they involve, based on the best available knowledge, to enable them to make good decisions about engaging with services.<sup>328</sup> In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, Queensland-based WWILD Sexual Violence Prevention Association recommended that to ensure services are accessible for people with disability – particularly those with an intellectual disability – information should be presented over time, using aids and, where appropriate, involving a support person.<sup>329</sup> The Care Leavers Australasia Network told us that many survivors who are care-leavers ‘don’t have intellectual disabilities but do have literacy difficulties created from their time in “care”’.<sup>330</sup> Victims and survivors from culturally and linguistically diverse backgrounds may also require translated information about available services relevant to their particular communities. In its submission to this issues paper, Anglicare Australia noted that while providing information in multiple languages can reduce barriers to accessing services, the information also needs to be culturally appropriate and meaningful, with the individual or community at the centre of the process.<sup>331</sup> To be accessible, services should ensure that information is provided through a range of mediums, including Plain English and audio formats and, where appropriate, in multiple languages.<sup>332</sup>

Affordability is a critical issue for survivors of child sexual abuse who are seeking support. As discussed in Volume 3, *Impacts*, many survivors told us that the child sexual abuse they experienced had long-term consequences for their education, employment and overall economic security. More than half of the survivors (55.7 per cent) who attended our private sessions and spoke to Commissioners about the impact of child sexual abuse described negative educational and economic outcomes. Research suggests that survivors of child sexual abuse may be more likely to access income support than those with no history of abuse.<sup>333</sup> They are also more likely to earn low incomes.<sup>334</sup> This means it is particularly important that services are affordable for victims and survivors of institutional child sexual abuse. Multiple submissions to our *Advocacy and support and therapeutic treatment services* issues paper recommended that survivors of child sexual abuse in institutions have access to these services at no cost.<sup>335</sup>

## Acceptability

An acceptable service system considers the diversity of individuals who have been affected by institutional child sexual abuse and is responsive to their lived, social and cultural contexts. Services should be culturally appropriate and aware of needs related to disability, gender and sexuality, particularly in regional areas where choice of services is limited. This involves agencies reviewing their own practices and adapting them to meet the needs of different victims and survivors and their communities. Staff should have the skills and capability to respond effectively to diverse needs or collaborate with other agencies to meet those needs.



Services available universally, as well as those targeted to specific populations, are part of an acceptable service system. For example, victims and survivors with disability may seek services from the mainstream and disability-specific sectors. Some submissions to our *Advocacy and support and therapeutic treatment services* issues paper emphasised the importance of mainstream services becoming disability competent and disability specialist services becoming trauma-informed.<sup>336</sup> All services should be prepared and able to reach and respond to victims and survivors from diverse backgrounds.

A range of social and cultural contexts shape victims' and survivors' needs. These contexts should be taken into account to inform service system responses. For example, recovery for many Aboriginal and Torres Strait Islander survivors must take account of the historical context and impacts of colonisation. A literature review we commissioned about the service needs of different populations identified that services for Aboriginal and Torres Strait Islander people should 'be informed by an enhanced understanding of, and engagement with, the complex histories, cultures and contemporary social dynamics of Aboriginal and Torres Strait Islander populations'.<sup>337</sup> An acceptable service system ensures cultural safety, free from assault, challenge or denial of a person's identity and what they need.

Understanding the importance of culture in working with victims and survivors was identified by several service providers in submissions to our *Advocacy and support and therapeutic treatment services* issues paper.<sup>338</sup> Micah Projects described working respectfully with victims and survivors in ways that are compatible with their cultural strengths and needs. They describe practice that is:

grounded in an understanding that each individual and family will have differing cultural contexts, practices and support needs, recognizes that relationships develop with trust and over time, knows the importance of ensuring people can review material or participate in conversations in their first language, and seeks to prioritize choice ...<sup>339</sup>

Adapting practices to be culturally appropriate when working with victims and survivors involves willing acceptance of their cultural values and expectations, and those of their community. For example, taboos surrounding sex and sexuality exist across society, however, the dynamics of taboos can be experienced in different ways for different communities. We heard that Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities need services that consider culturally acceptable ways of discussing sex and sexuality that are relevant to individual survivors.<sup>340</sup>

We also heard that service providers need to consider the model of services being offered. Individual counselling, for example, is not necessarily relevant or familiar for many people from culturally and linguistically diverse backgrounds.<sup>341</sup> Several sexual assault services told us that a different approach to engaging victims from culturally and linguistically diverse backgrounds was required and proposed a community development or community-based approach.<sup>342</sup> This approach involves services establishing relationships with trusted community members and elders, providing counsellors for community-based services, or providing services in settings such as kindergartens, where diverse communities may intersect.



An acceptable service system also means adapting practices to be sensitive to disability. Many services told us about the importance of being responsive to disability.<sup>343</sup> A study we commissioned found that while there is little high-quality research on interventions for victims and survivors with disability, the available research suggests that it is possible to adapt verbal and non-verbal therapies for interventions for people with intellectual disability – including psychodynamic, behavioural, cognitive and other techniques – although there are no treatment studies that establish efficacy.<sup>344</sup> There is some evidence that group therapy may be useful for people with intellectual disability who have experienced sexual abuse, as a way of developing socio-sexual understanding, promoting social interaction and reducing isolation.<sup>345</sup>

An acceptable service system is also sensitive to gender and sexuality.<sup>346</sup> For example, as we consider in Volume 4, *Identifying and disclosing child sexual abuse*, research suggests that boys may be reluctant to disclose because of factors related to male socialisation.<sup>347</sup> In our *Nature, cause and impact of child sexual abuse* case study, we were told by Dr Gary Foster – who manages a support service for men who experienced sexual abuse in childhood – about the debilitating impact these norms can have on men throughout their lives:

I've had men sit there and tell me, 'I should have been able to stop it', because of that culture that men should be able to cope, and, 'My double failing is, one, I didn't get away at the age of 12, but the fact is now, at 57, I'm not coping, and, as a man, I should be able to cope with anything that's thrown at me' ... What you're not meant to be, when you're a male, is vulnerable.<sup>348</sup>

Many service providers talked about the importance of having qualified workers from diverse communities provide services to their relevant populations.<sup>349</sup> We also heard about the need for training of the broader workforce to ensure responsiveness to cultural contexts.<sup>350</sup> We heard about the importance of sharing knowledge and expertise between services. Legal support service knowmore proposed models that support Aboriginal and Torres Strait Islander elders, key community members and community service workers to contribute their cultural expertise and knowledge, for example, by providing professional development to practitioners in the sexual assault service sector to ensure their practice is culturally safe.<sup>351</sup>

In Section 2.5.4 we discuss the importance of healing approaches for Aboriginal and Torres Strait Islander people and communities.

## High quality

A high-quality service system is informed by evidence, well-trained and supported, outcome focused, accountable and subject to ongoing evaluation. Such a system is essential to ensure victims and survivors receive effective advocacy and support and therapeutic treatment.

Evidence-informed practice should be an integral element of a high-quality service system. For therapeutic treatment services, treatment decisions are best made in a consultative process that links informed choice and the best available evidence of what works (including both instrumental and conceptual knowledge) with clinical judgment by qualified practitioners who are experienced in working with victims and survivors of child sexual abuse. As discussed in Section 2.4, therapeutic treatments should be deliberate and purposeful and based on valid conceptual knowledge about trauma, including complex trauma and intergenerational trauma. They should also include a clearly identifiable, articulated and legitimate theory of change. Treatments should focus on safety, attachment, relationships, emotional regulation, and integration and processing.<sup>352</sup> The study of trauma arising from child sexual abuse is relatively recent, as is the application of different therapeutic approaches. There is a need for more high-quality evidence on the effectiveness of many advocacy and support and therapeutic treatment modalities. As this body of evidence emerges it should be incorporated into practice by specialist trauma therapists.

Quality services empower victims by facilitating their engagement in treatment and giving them feedback opportunities. In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, Victorian family support organisation drummond street services said that services should foster respectful, ongoing dialogue between service and client that acknowledges the dynamic nature of recovery from the impacts of child sexual abuse.<sup>353</sup>

Service agencies<sup>354</sup> and the Australian Government and state and territory governments<sup>355</sup> told us that the advocacy and support and therapeutic treatment workforce should consist of qualified and appropriately skilled staff. Therapists should have a sound understanding of developmental and trauma theory.<sup>356</sup> Practitioners require specialised skills to work with child victims and non-offending family members and caregivers.<sup>357</sup> Service providers told us this could be achieved through: implementing mandatory trauma training or accreditation requirements for professionals working in the sector;<sup>358</sup> providing regular professional development;<sup>359</sup> developing practice groups that meet face to face or online, or networks of multidisciplinary workers;<sup>360</sup> and establishing practice guidelines.<sup>361</sup>

We are also of the view that for effective practice, staff should have access to regular external professional supervision to mitigate any impacts of vicarious trauma. Professional supervision involves a dialogue between front-line practitioners and other more experienced practitioners (or, for senior practitioners, peers) to provide opportunities for counselling, debriefing, assistance, mentoring and clinical development. It is distinct from management in that where management aims to ensure that the practitioner's activities are in line with the priorities of the agency, professional supervision aims to foster the practitioner's clinical capacity and skill and provide opportunities for self-care. Professional supervision is important for ethical practice.<sup>362</sup> Several submissions to our issues paper identified supervision as an important means of promoting service quality, ensuring safety and maintaining practitioners' wellbeing.<sup>363</sup> It assists agencies to retain staff, as well as maintain and further develop skills and knowledge. Commissioned research that surveyed support services for victims and survivors noted that ongoing support and debriefing of staff can also help reduce impacts of vicarious trauma.<sup>364</sup>

Front-line services that support victims and survivors should be subject to ongoing evaluation using high-quality methodologies that are sensitive to the nature and dynamics of complex trauma and recovery and the needs of diverse populations. Through submissions to our *Advocacy and support and therapeutic treatment services* issues paper, we were told that it is unusual for services to be provided with funding to conduct evaluations and that service agencies generally prioritise service delivery over evaluation.<sup>365</sup> To ensure that service providers can conduct evaluations while maintaining the quality of front-line services, the costs of evaluation should be incorporated into funding agreements. This would improve the quality of service provision over time.<sup>366</sup> Funding should also be flexible enough to allow service providers to modify practice if recommended by the evaluation process.

## 2.5.4 Healing approaches for Aboriginal and Torres Strait Islander communities

We heard from a range of organisations and individuals that Aboriginal and Torres Strait Islander healing approaches should be part of the formal service system, in addition to culturally safe mainstream services.<sup>367</sup> We acknowledged and discussed this view in our *Redress and civil litigation* report.<sup>368</sup> Many submissions to our consultation paper on redress and civil litigation outlined the specific needs of Aboriginal and Torres Strait Islander survivors, including 'responding to transgenerational trauma and the need for culturally safe healing programs'.<sup>369</sup> In our *Redress and civil litigation* report we presented findings from national and international research, evidence from our public hearings, and information from submissions and consultations to demonstrate the need for culturally appropriate models of healing and support.<sup>370</sup>

While we focused on counselling and psychological care as an appropriate response in a formal redress scheme, we made a commitment to consider other forms of support as part of our work to examine the broader service system.

Two aspects underpin the need for specific Aboriginal and Torres Strait Islander healing approaches. The first is the historical context of collective trauma; and the second is the importance of culturally informed healing methodologies, beyond Western, clinical forms of therapy.

## Understanding the historical context of collective trauma

Healing for many Aboriginal and Torres Strait Islander survivors of institutional child sexual abuse must take account of the historical context and impacts of colonisation. Previous inquiries have documented how this context included violent conflict that destroyed large portions of Aboriginal and Torres Strait Islander populations, followed by the implementation of discriminatory laws and policies that led to the Stolen Generations.<sup>371</sup> Our commissioned research has summarised key elements of this history and the repercussions for Aboriginal and Torres Strait Islander communities today.<sup>372</sup> In Volume 2, *Nature and cause* we acknowledge and discuss the relevance of this historical context to our inquiry.

In consultations with survivor groups and their communities, many people told us of the impact of the forced removal of tens of thousands of Aboriginal and Torres Strait Islander children to institutions under Aboriginal Protection Acts which occurred until well into the second half of the 20<sup>th</sup> century.<sup>373</sup> In 1997, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (Bringing them home)* found that sexual abuse of children in these institutions was common, as was physical and emotional abuse and neglect, occurring within a broader societal context of racial discrimination and cultural abuse.<sup>374</sup> As we discuss in Volume 5, *Private sessions*, many Aboriginal and Torres Strait Islander survivors told us they were sexually abused in the 1950s and 1960s in institutions still operating under this legislative regime and its accompanying assimilation policies. Research we commissioned outlines how these policies not only enabled the sexual abuse of Aboriginal and Torres Strait Islander children, but severely disrupted relationships between individuals and their kin and country.<sup>375</sup> Volume 4, *Identifying and disclosing child sexual abuse* discusses the deep-seated fear and mistrust of non-Indigenous workers and mainstream service systems that is a legacy of this treatment. In this context, it is not only individuals who seek to heal, but also communities.

Survivors and their families told us forced removal involving cultural, physical and often sexual abuse in institutions was the formative experience of a large number of Aboriginal and Torres Strait Islander children, across multiple generations. As a result, we heard that for many, it is an instinctive act of self-preservation to avoid contact with non-Aboriginal authorities and services.<sup>376</sup>

Survivors also emphasised how forced removal has affected the wellbeing and capacity of not only individuals, families and particular cohorts, but entire Aboriginal and Torres Strait Islander communities. We were told broken connections to culture and community and the disruption of social networks and roles are fundamental to this collective trauma, so that repairing these connections is essential to recovery from abuse:<sup>377</sup> ‘So for me ... healing involves reconnecting to Country, culture, language, family, community and the repairing of all of these relationships’.<sup>378</sup>

Our research suggests that an understanding of this historical context and its legacy of collective and intergenerational trauma is essential to understand the experiences of, impacts on and support needs of Aboriginal and Torres Strait Islander victims and survivors of child sexual abuse.<sup>379</sup>

## Culturally informed ways of healing

The second aspect that reinforces the need for Aboriginal and Torres Strait Islander healing approaches is that Western models of therapeutic support and recovery may be inappropriate or insufficient for many Aboriginal and Torres Strait Islander survivors.<sup>380</sup> The Victorian Aboriginal Child Care Agency raised this concern in its response to our *Advocacy and support and therapeutic treatment services* issues paper, stating: ‘While it is important that choice and access must be available, our experience shows that few Aboriginal survivors find mainstream counselling services to be beneficial’.<sup>381</sup> Culturally informed ways of healing are required.

Concepts of health and wellbeing can be culturally specific. Clinical practice has demonstrated that Aboriginal and Torres Strait Islander peoples have culturally effective ways of healing from trauma and loss.<sup>382</sup> While Western approaches to therapeutic intervention tend to focus on the individual, Aboriginal and Torres Strait Islander approaches emphasise family and human relatedness.<sup>383</sup> The *Bringing them home* report noted:

Traditional Aboriginal culture, like many others, does not conceive of illness, mental or otherwise, as a distinct medical entity. Rather, there is a more holistic conception of life in which individual wellbeing is intimately associated with collective wellbeing. It involves harmony in social relationships, in spiritual relationships and in the fundamental relationship with the land and other aspects of the physical environment. In these terms, diagnosis of an individual illness is meaningless or even counterproductive if it isolates the individual from these relationships.<sup>384</sup>

Research has shown that some Aboriginal and Torres Strait Islander people only access mainstream health services ‘when all traditional avenues had been exhausted and there was no other treatment option available’.<sup>385</sup> As highlighted in the report *Breaking the silence, creating the future: Addressing child sexual assault in Aboriginal communities in NSW*:

The traumatic impact that colonisation, dispossession, marginalisation and the stolen generation has had on Aboriginal families and communities has resulted in a mistrust of the system and a reluctance to engage services that have in the past been so damaging to Aboriginal communities.<sup>386</sup>

Mistrust of mainstream services and the mismatch between Western models of healing and Aboriginal and Torres Strait Islander worldviews drives a need for culturally informed healing for survivors of child sexual abuse in institutions. Aboriginal and Torres Strait Islander peoples, in common with indigenous communities across the world, have drawn on 'Indigenous knowledge and Indigenous ways of seeing and being in the world and the cosmos'<sup>387</sup> to develop appropriate healing approaches.

## Aboriginal and Torres Strait Islander healing approaches

A service system that is responsive to the specific needs of Aboriginal and Torres Strait Islander survivors of institutional child sexual abuse requires culturally informed ways of healing to be available, alongside other supports. We consistently heard from advocacy and support organisations about the need for approaches to healing that could address cultural dimensions and the collective impacts of trauma, including the fracturing of relationships and the loss of cultural identity.<sup>388</sup> In community consultations we also heard about the importance of collective healing:

The strength that comes through collective healing ... is really about community healing ... it is reconnecting with the communities ... So part of it is going back to those communities ... restoring our family structures and that's restoring the community.<sup>389</sup>

In our *Nature, cause and impact of child sexual abuse* case study, psychologist Ms Kelleigh Ryan gave evidence that:

cultural practices, being involved in ceremony, being on Country, dance, art, you know, ceremonies. All of these things actually, we know now, therapeutically, are healing for those neurological pathways that are damaged in trauma.<sup>390</sup>

Through our engagement activities and consultations we heard about a wide variety of healing approaches across Australia for Aboriginal and Torres Strait Islander survivors.<sup>391</sup> Structured programs as well as informal supports have been provided, combining peer support, deep listening, guidance from Elders and cultural activities such as being on Country and conducting ceremony.<sup>392</sup> Healing programs can involve elements of mainstream support and therapy, within culturally safe and supported settings. Several survivors described going back to Country and connecting with kin and culture as healing.<sup>393</sup>

Support for Aboriginal and Torres Strait Islander healing approaches is now well established.<sup>394</sup> Previous reports, including *Bringing them home*,<sup>395</sup> *Putting the picture together: Inquiry into response by government agencies to complaints of family violence and child abuse in Aboriginal communities*<sup>396</sup> and *The Aboriginal and Torres Strait Islander Women's Task Force on Violence report*,<sup>397</sup> recommended expanding Aboriginal and Torres Strait Islander healing programs. Following the Australian Government's Apology to Australia's Indigenous peoples in 2008, it established the Healing Foundation.<sup>398</sup> The foundation is informed by a nationwide consultation process and draws upon knowledge from the Aboriginal Healing Foundation in Canada, which was set up in 1998 to promote community-level healing of the legacy of sexual abuse in the residential school system.

The Healing Foundation has reviewed the literature on evaluations of Aboriginal and Torres Strait Islander healing programs and reports that healing approaches have positive impacts on 'health status and health disparities', as well as 'knowledge and skills' acquisition by community members and the development of individual, family and community capacity'.<sup>399</sup> The Foundation identified that 'characteristics that result in effective healing programs are those':<sup>400</sup>

- developed to address issues in their local community
- driven by local leadership
- based upon well-developed evidence and theory
- combining both Western methodologies and traditional healing in their treatment theory base
- informed about and cognisant of the impact of colonisation and intergenerational trauma and grief
- building upon individual, family and community capacity through the acquisition of knowledge and skills
- incorporating strong evaluation frameworks
- with a proactive rather than reactive focus'.

Formal research on Aboriginal and Torres Strait Islander healing approaches is in the early stages<sup>401</sup> and while individual evaluations show positive outcomes,<sup>402</sup> many programs have not been sufficiently documented to enable their review.<sup>403</sup> Notwithstanding these limitations, emerging evidence substantiates the theory of change behind such approaches. There is a growing consensus that 'connection to culture is associated with better emotional, social and physical health of Aboriginal and Torres Strait Islander peoples'<sup>404</sup> and may also help Aboriginal and Torres Strait Islander children to foster 'positive self-esteem, emotional strength and resilience'.<sup>405</sup> The Western Australian Aboriginal Child Health Survey, using language as a proxy for culture, provides empirical evidence to underpin these assertions.<sup>406</sup>

Strengthening the evidence base is essential to inform good practice and to guide policy and funding decisions. It is important that evaluation methodologies recognise Aboriginal and Torres Strait Islander concepts of health and wellbeing and take account of the broader context of collective and intergenerational trauma. This means culturally appropriate outcome measures and evaluation processes should be applied.<sup>407</sup> Research suggests there is growing understanding of the inadequacies of mainstream evaluation methods for Aboriginal and Torres Strait Islander approaches:

Theorists and practitioners agree that current clinical and biomedical methods are not appropriate for the evaluation of community based healing programs, and this is supported by the literature pertaining to community based primary prevention programs.<sup>408</sup>

Requiring culturally appropriate evaluation methodologies is consistent with Australian ethical research guidelines.<sup>409</sup>

In common with several previous inquiries,<sup>410</sup> we recognise such approaches are only one component of a culturally responsive service system. In seeking to address both the trauma of child sexual abuse and the intergenerational and collective trauma that compounds the impacts of child sexual abuse, Aboriginal and Torres Strait Islander healing approaches have a key role to play.

We are satisfied that Aboriginal and Torres Strait Islander healing approaches should be available and accessible to victims and survivors of institutional child sexual abuse as part of support services in all jurisdictions. These approaches should be evaluated against culturally appropriate outcome measures using culturally appropriate methodologies, to contribute to evidence of best practice.

Aboriginal and Torres Strait Islander healing approaches are not a replacement for other supports, but should exist alongside specialist services, culturally safe mainstream services and Aboriginal Community Controlled Health Services with appropriate clinical expertise.



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## 3 The shape of the service system

### 3.1 Overview

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This chapter provides an overview of existing services that assist victims and survivors with the wide-ranging impacts of child sexual abuse.

The current service system is expansive, comprising a tangle of participants, professionals, services, settings and governing arrangements across various government portfolios.<sup>1</sup> Advocacy and support and therapeutic treatment are provided through mainstream, community-based and specialist services by government, non-government, not-for-profit, faith-based and private service providers.

There is no single entry point to the service system for victims and survivors of institutional child sexual abuse. Victims and survivors might enter the system through, for example, a helpline, website, general practitioner or community health service. Survivors might seek assistance from various services at different times in their lives and, because many survivors experience multiple issues at once, they might access several services simultaneously. Many victims do not present to services with child sexual abuse as the main or even stated issue.

Some services, such as Medicare, are broad-based. Others are targeted to specific groups, including victims of trauma and, specifically, victims of child sexual abuse.

Children and young people interact with different service systems and access them in different settings than adults do. The systems they interact with include schools, out-of-home care, youth detention and the child and adolescent mental health service system. Service systems and settings specific to older people include residential and community-based aged care.

All the identified service types play a role in supporting victims and survivors of child sexual abuse, and should work together to meet their wide range of needs.

## 3.2 Services providing advocacy and support and therapeutic treatment

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The types of services victims and survivors access to address their advocacy and support and therapeutic treatment needs include:

- mainstream services, such as mental health, alcohol and other drug services, community health services, general practitioners (GPs) and private practitioners, such as psychologists
- community support services, including services for specific populations – such as Aboriginal Community Controlled Health Services, multicultural organisations or peer-based survivor support groups
- specialist services, such as child and adult sexual assault services.

Victims and survivors sometimes access advocacy and support and therapeutic treatment through service system responses to reported cases of abuse, such as through child protection, redress and criminal justice responses. Victims and survivors also seek services through the institutions they are already engaged with, which could include school, out-of-home care, custodial or aged care settings.

Victims and survivors may see a range of different workers in these services, including GPs, psychiatrists, psychologists, nurses, mental health or drug and alcohol workers, social workers, occupational therapists, peer workers and other personal care staff.

There is no single model of service that provides advocacy and support and therapeutic treatment. Some services provide only advocacy and support or only therapeutic treatment. Others provide a combination of these functions.

The following sections describe the various service systems of mainstream, community support and specialist services. They include a brief description of other system responses and institutional settings in which victims seek advocacy and support and therapeutic treatment.

Services for children who exhibit harmful sexual behaviours and may also be victims of child sexual abuse are discussed in Volume 10, *Children with harmful sexual behaviours*.

### 3.2.1 Mainstream services

Mainstream services are service systems available to all Australians, including health, mental health, aged care, education, justice, housing and employment services. While mainstream services are not specifically set up to address child sexual abuse, many survivors engage with them throughout their lives for assistance relating to the impacts of child sexual abuse. Engagement with a mainstream service may be a victim's or survivor's first or only contact with a support service. For other victims and survivors it may be an entry point to longer-term therapeutic care. When survivors present to mainstream services, their history of abuse often remains invisible to the clinician.<sup>2</sup>

Health and mental health services are key mainstream services victims and survivors access. In our private sessions, 63.1 per cent of survivors who said they accessed formal services mentioned accessing private psychological support, and another 17.0 per cent mentioned other mainstream services.<sup>3</sup> We commissioned a study that explored pathways to services for survivors and their families. Survivors and their families who participated in the research identified doctors and other medical professionals as well as counselling services as sources of helpful information immediately following abuse.<sup>4</sup> Research studies suggest that there is a higher prevalence of child sexual abuse history among clients of some mainstream services than among the general population.<sup>5</sup>

Table 9.1 describes key mainstream services and what we learned about why victims and survivors may access these services.

**Table 9.1 – Key mainstream support services for victims and survivors and reasons for access**

Service type	Description
<b>Mental health services</b>	<p>Mental health services are provided through hospital, residential, community, private and non-government organisation services.</p> <p>Victims and survivors of institutional child sexual abuse may use a variety of mental health services to address the experience of child sexual abuse and any psychological trauma. In some situations, hospital emergency departments may be an initial point of access due to crisis presentations such as suicide attempts.</p>
<b>Alcohol and other drug services</b>	<p>Many survivors enter the service system through alcohol and other drug services, which are provided in a range of settings. Survivors may seek to manage their addictions, change patterns of behaviour or address the way they are coping with the impacts of child sexual abuse.</p>
<b>Community health services</b>	<p>Government-funded community health services provide a range of services that generally comprise multidisciplinary teams of health and allied health professionals. This includes over 150 Aboriginal Community Controlled Health Services or Aboriginal Medical Services across Australia that aim to deliver culturally appropriate healthcare to Aboriginal and Torres Strait Islander people.</p> <p>Victims and survivors may use a community health service to manage a range of practical and psychological issues, and it may be the only service available in their area where they can receive counselling.</p>
<b>General practice</b>	<p>General practice is a fundamental service for victims and survivors and is often the first point for seeking assistance. GPs treat physical health issues, develop mental health care plans and provide referrals to allied health professionals. Victims and survivors also engage with allied health professionals and nurse practitioners who are sometimes employed in general practice settings.</p>
<b>Private practice</b>	<p>Many victims and survivors access a psychologist, psychotherapist, psychiatrist, counsellor or social worker in private practice via the Medicare system. Victims and survivors may also use private practitioners who they find and pay for themselves. Some institutions refer victims and survivors to private practitioners and may also pay for the cost of the practitioner's services.</p>
<b>Gateways and helplines</b>	<p>There are several telephone and online helplines – such as Lifeline, Kids Helpline, <i>beyondblue</i>, headspace, MensLine and ReachOut.com – that victims and survivors can access. Although these examples are not specifically targeted at addressing experiences of child sexual abuse, they can act as gateways into the service system and may help with symptoms that emerge because of the abuse, including poor mental health and suicidal ideation (suicidal thoughts). Self-help websites may provide another level of support, which people can access in their own time and in private, rather than interacting with professionals.</p>

Victims and survivors also seek assistance from other mainstream services – including aged care, education, legal, housing and employment services – to address the broader impacts associated with child sexual abuse. Advocacy and support and therapeutic treatment services play an important role in assisting victims and survivors to navigate these broader services. Mainstream services are also an essential, highly visible referral point for victims seeking access to specialist services.

### 3.2.2 Community support services

Community support services cover a broad range of services that assist individuals and groups who are experiencing crisis or persistent hardship, with the aim of building their capacity and resilience. The types of programs delivered include: general health services; accommodation support; respite; community support, such as therapy and behaviour intervention; community access, such as life skills development and recreation programs; employment support; in-home support; support for family reunions; peer support; assistance with records; legal support; case management; individual, family and group counselling; and advocacy, referrals and information. Community support services are often delivered by not-for-profit service providers, but can also be delivered by government and other non-government organisations.<sup>6</sup>

Of the survivors in our private sessions who said they accessed any formal service, 18.3 per cent mentioned accessing a community support service.<sup>7</sup>

While community support service providers do not generally provide services exclusively to child sexual abuse victims, many provide targeted programs for victims and survivors and some receive funding to support individuals who have engaged with the Royal Commission.<sup>8</sup> Some community support services are led by survivors.

Many community support services target specific populations, such as Aboriginal and Torres Strait Islander communities, people with disability, people from culturally and linguistically diverse backgrounds, children and young people, victims of crime, and older people. Some service providers deliver advocacy and support services to adults who have been in institutional care settings, acting as a 'one-stop shop' to assist adult care-leavers. These services provide assistance that may include counselling, support for family reunions, assistance with records, case management, advocacy, referrals and information.

While engagement with mainstream services tends to be based on an individual's symptoms, engagement with a service for a specific population group is often based on an individual's background and experience.

As with mainstream services, victims and survivors may not disclose their history of child sexual abuse to community support services.



### 3.2.3 Specialist sexual assault services

Specialist sexual assault services are those whose core focus is addressing the impacts of sexual assault or child sexual abuse. Generally, specialist sexual assault services provide free and confidential information, medical treatment and forensic examinations, crisis and ongoing counselling and support, and court support for victims of sexual assault as well as non-offending family members, carers and friends.<sup>9</sup> Of the survivors in private sessions who said they accessed any formal service, one in nine (11.1 per cent) mentioned accessing a specialist sexual assault service.<sup>10</sup>

We recognise that many of the support services that victims and survivors access and value are considered specialist in other contexts, for example, services tailored and targeted to the Stolen Generations, Forgotten Australians and Former Child Migrants, or to addressing mental health and alcohol and other drug issues. For the purpose of our inquiry, we considered specialist services to be those with sexual assault and child sexual abuse as their core focus.

There is no set model of sexual assault service provision in Australia, and delivery varies between jurisdictions.<sup>11</sup> In some states and territories, sexual assault services are provided as part of the health system, while in others they are funded by state or territory governments but delivered by the non-government sector.<sup>12</sup> While most practice and policy initiatives in the sexual assault sector have focused on women and children in the past,<sup>13</sup> many sexual assault services now also support male survivors.<sup>14</sup> Child and adolescent sexual assault services may be provided by specialist sexual assault services or another service system.<sup>15</sup>

Victims and survivors can contact Australia-wide crisis telephone helplines for information and support regarding sexual assault. All states and territories also operate their own crisis telephone helplines.<sup>16</sup>

Services for children who exhibit harmful sexual behaviours and may also be victims of child sexual abuse are discussed in Volume 10, *Children with harmful sexual behaviours*.

### 3.2.4 Other systems and institution-specific responses

Advocacy and support and therapeutic treatment services for children or adults may also be provided through other systems such as child protection, criminal justice or redress schemes. Individual institutions also sometimes themselves offer direct services, to children or adult victims and survivors.



## System responses to reported cases of abuse

Systems that are set up to receive reports of child sexual abuse may provide or refer a victim or survivor to advocacy and support or therapeutic treatment services. Some system responses are targeted at children and young people – for example, the statutory child protection system. Others, like redress and criminal justice responses, may be accessed by both children and adults.

In Australia, state and territory governments have statutory responsibility for protecting children from child abuse and neglect. Relevant departments are responsible for securing the safety and welfare of children who have been, or are currently at risk of being physically, sexually or emotionally abused or neglected, or whose parents or caregivers are otherwise unable to provide adequate care or protection. The threshold for intervention by child protection authorities differs across the nation. While departments are operationally focused on familial abuse, they may under some circumstances respond to allegations of child sexual abuse in institutional settings.

Children, young people and their families can be referred to various early intervention and family support services as part of, or in addition to, the child protection response. In this sense, the child protection system could potentially be a pathway to advocacy and support and therapeutic treatment services for some child victims. Evidence before us, however, suggests this is only likely to occur under a very restricted set of circumstances and is not widely available. We note access to such support is structured differently across different jurisdictions.

Another pathway to support may be through different forms of redress from institutions or governments. Child or adult survivors of institutional child sexual abuse seeking redress may receive support as part of the application process or as an outcome of the process.<sup>17</sup>

As part of the criminal justice response to reported cases of child sexual abuse, support may be provided through services for witnesses and victims of crime. State and territory governments operate schemes that provide counselling and psychological care to victims of crime, either directly or through funding services.<sup>18</sup>

While not a service provider, the Royal Commission provided a means of entry to the service system for many survivors. Between 7 May 2013 and 31 May 2017, 6,875 survivors told their stories to us in a private session as part of our inquiry. Survivors received short-term support through our counsellors and were referred to external advocacy and support and therapeutic treatment services.

## Institutional settings in which victims and survivors are engaged

Some advocacy and support and therapeutic treatment services are available through institutions that victims and survivors already engage with, such as educational, out-of-home care and detention settings. Services are not available through all institutions, and those that are available may not specifically address child sexual abuse. We have been told of a range of barriers to accessing services that exist for victims and survivors engaged in these institutional settings. These are discussed in Chapter 4.

Primary, secondary or tertiary educational institutions may provide in-house support services to children and young people, for example, from a school counsellor. Some educational institutions also have links with external support services.

Out-of-home care services provide care for children and young people under 18 years of age who cannot live in the family home for safety reasons or family crisis. These programs include foster care, kinship care and residential care.<sup>19</sup> Out-of-home care systems provide some support for children and young people and their carers to meet needs associated with child sexual abuse. Supporting children and young people in out-of-home care is discussed in Volume 12, *Contemporary out-of-home care*.

Victims and survivors in detention settings, including youth detention and adult prisons, may have access to psychological services in relation to their mental health or offending.<sup>20</sup> We were also told about services in detention settings that focus on providing therapeutic support for victims and survivors of child sexual abuse.<sup>21</sup> One survivor, 'Dave Peter', told us he decided to take advantage of therapeutic support available in prison:

I've been speaking to a psychologist since I've been in here about everything that's happened, and I'm seeing him again tomorrow, and he's going to be organising a support program of seeing a psychologist on the outside and basically different support groups ... I'm prepared to follow this all the way to the end of it.<sup>22</sup>

## 3.3 Governance and funding arrangements

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The services that victims and survivors of child sexual abuse use are governed and funded by a web of arrangements. Services fall under various government portfolios, including health, children and families, human and social services, and justice. Each portfolio has its own national framework and strategies that guide service delivery and workforce development.

Many services are funded by governments, some by a combination of Australian and state or territory funding. Some funding comes from portfolios such as the attorney-general's, social services, health or, specifically, mental health. Some services receive private and philanthropic funding. Such varied funding sources can cause services to adopt priorities, approaches and delivery models to meet the funding organisation's expectations, which may not align with those of the client.

Each service system is multifaceted. The Australian health system, for example, is a network of public and private providers, settings and participants.<sup>23</sup> In addition, as the health sector often interacts with the welfare sector, many people find they must navigate multiple service sectors. Australian, state and territory government responsibilities are split. The Australian Government is responsible for national policies and Medicare, and also funds community-controlled Aboriginal and Torres Strait Islander services.<sup>24</sup> State and territory governments are responsible for public and community health services, including mental health and alcohol and other drug services, while local governments deliver some community and home-based health and support services.<sup>25</sup> Responsibility is shared between all jurisdictions for workforce training and funding public health programs and Aboriginal and Torres Strait Islander health services.<sup>26</sup>

The service systems that victims and survivors may use vary across Australia. For example, although child protection processes in each jurisdiction are broadly similar, services that respond to allegations of child sexual abuse operate under specific legislation and are delivered differently in each state and territory.<sup>27</sup> There is also considerable variation in the types of community health services available across jurisdictions, as there is no national strategy for these services.<sup>28</sup>

### 3.3.1 Funding programs for services to victims and survivors

Due to diverse governance arrangements, funding for services for victims of child sexual abuse is fragmented. Therapeutic treatment services can be funded by the Australian Government through Medicare, by state and territory governments via targeted program funding, and by survivors themselves.<sup>29</sup> Non-government organisations are often funded by the federal or state and territory governments, or a combination of both.<sup>30</sup> Some organisations also rely on donations and fundraising.

The Australian Government Department of Social Services funded 37 organisations to provide community-based support services to people who have been affected through their engagement with the Royal Commission. Four of these services were funded specifically to provide information, referrals and counselling through national telephone and online services.<sup>31</sup> There were also 15 state- and territory-based services, as well as specialist support services for men, women, people with disability, Aboriginal and Torres Strait Islander people, Forgotten Australians and Former Child Migrants, and people who were abused in religious institutions.<sup>32</sup>

Funding for these services was allocated for the period 1 July 2013 to 30 June 2018. During 2013–14 and 2014–15, the services provided over 164,800 client activities, including assessment, information, referral, education, counselling, assistance in preparing a submission, support (including in attending a Royal Commission hearing) and case management.<sup>33</sup> In 2017 the Australian Government committed funding for legal and community-based support services for survivors as part of the Commonwealth Redress Scheme.<sup>34</sup>

### 3.4 How service systems are changing

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The service system in Australia is undergoing substantial transformation as a result of a number of inquiries, including *Contributing lives, thriving communities – The National Review of Mental Health Programmes and Services in 2014*<sup>35</sup> and reforms such as the implementation of the National Disability Insurance Scheme and the creation of Primary Health Networks. These have already resulted in changes to service design, structure and models of care, and further changes are anticipated in the short to medium term. These reforms aim to provide a more streamlined and coordinated service sector that is focused on the needs of the client and will reduce duplication and fragmentation.

#### 3.4.1 Mental health reform

There is a significant level of reform occurring in Australia's mental health sector, which is changing the way mental health services are provided and who provides them. These reforms provide an opportunity to enhance governance, quality and safeguards in this sector.

We have heard that victims and survivors of all ages face a number of challenges when using the mental health system, including:

- fragmentation of the system, making it hard to access<sup>36</sup>
- mental health staff not having skills or experience in identifying and responding to trauma and child sexual abuse<sup>37</sup>
- services focusing on treating presenting symptoms, rather than underlying causes<sup>38</sup>
- services being inaccessible for many people, including for people with physical and intellectual disability<sup>39</sup>
- a lack of access to support services specific to Aboriginal and Torres Strait Islander people and mainstream services not being culturally safe<sup>40</sup>
- services not being available for secondary victims<sup>41</sup>
- services being limited in rural and regional areas.<sup>42</sup>

A review of existing mental health programs and services across the government, non-government and private sectors<sup>43</sup> has led to a series of mental health reform activities. These include: Primary Health Networks delivering a range of government programs previously delivered in the mental health sector; the development of a digital gateway; refocusing mental health care services to a stepped care model; nationally coordinated services for children and young people; increased access to services for Aboriginal and Torres Strait Islander people; care coordination for people with severe and complex mental illness; and national leadership through the Fifth National Mental Health Plan.<sup>44</sup>

Mental health services are moving to a person-centred approach that prioritises consumer choice and shifting their focus from acute intervention to early intervention.<sup>45</sup> These reforms, although not specifically focused on victims and survivors of child sexual abuse, may address many of the barriers to accessing mental health services that victims and survivors and professionals have identified. The reforms aim to develop a mental health system with better planned, coordinated and integrated services that are locally developed and equitable and that provide clients with easy access to information.

We know mental health services play a fundamental role for many victims and survivors when they attempt to receive advocacy and support and therapeutic treatment services to address the impact of child sexual abuse and associated trauma. It is anticipated that these reforms will have a significant impact on the use of mental health services by victims and survivors.

### 3.4.2 The National Disability Insurance Scheme

The Australian Government and state and territory governments have committed, through the National Disability Strategy 2010–2020, to a shared vision of an ‘inclusive Australian society that enables people with disability to fulfil their potential as equal citizens’.<sup>46</sup> The National Disability Insurance Scheme (NDIS) is part of this commitment and is being progressively rolled out across Australia, delivered by the National Disability Insurance Agency (NDIA). The NDIS aims to support people with permanent and significant disability, including people with a psychosocial disability related to a mental illness, by providing individualised packages of support to access a range of mainstream and community services.<sup>47</sup>

NDIS-funded support will be offered alongside existing government service systems, such as health (including mental health), education and housing. If a person with disability does not yet need NDIS-funded support, they will be referred to existing mainstream and community services.<sup>48</sup>

It is too early to assess what the NDIS means for victims and survivors of child sexual abuse with disability. However, we have been told of some of the potential challenges for the NDIS and the disability sector that are relevant to institutional responses to child sexual abuse, including:

- the rapid expansion of the disability workforce – potentially doubling in size – and subsequent difficulty for service providers in recruiting staff quickly<sup>49</sup>
- increasing pressure to ‘casualise’ the workforce, potentially resulting in less investment in training and a higher turnover of staff<sup>50</sup>
- the demands of training and accreditation of the workforce<sup>51</sup>
- the application of codes of conduct and practice standards to registered and unregistered providers<sup>52</sup>
- the need for a system of comprehensive police and Working With Children Checks for all workers, and a nationally consistent system that includes international checks<sup>53</sup>
- increased demand for advocacy services, with uncertain funding and resourcing for individual advocacy<sup>54</sup>
- the need for evidence-based education resources<sup>55</sup>
- the interaction between national and state and territory complaints mechanisms.<sup>56</sup>

Clarifying which governance roles are held at national and state/territory levels as support services transition to the NDIS is important, particularly as the block funding model moves to a consumer-directed market. Concerns about what this means, and whether quality and safety can be maintained within this model, have been raised in earlier inquiries and through our consultation processes.<sup>57</sup>

The role the NDIS will play in providing support and therapeutic interventions to people with disability who have experienced child sexual abuse must be considered. We have heard that accessing therapeutic services for children with disability who have experienced sexual abuse is ‘typically very problematic’.<sup>58</sup> Children with disability and their families are highly diverse, and should be expected to vary in whether they would prefer mainstream or disability-specific services.<sup>59</sup>

As noted, NDIS-funded support will work alongside existing government service systems. This means that the identification of service gaps, clarification of roles and responsibilities, and funding arrangements to address any coordination issues and ensure effective collaboration between service sectors will be required.

# Endnotes

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## 4 Barriers to help-seeking and effective service responses

### 4.1 Overview

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This chapter considers what we were told about barriers that prevent victims and survivors of child sexual abuse from receiving the advocacy and support and therapeutic treatment services they need.

First, we discuss barriers facing individuals seeking help. Social issues such as stigma can prevent individuals from reaching out for help. Many survivors told us that when they did seek help, the negative reactions they experienced were re-traumatising and made them pause when considering future disclosures. Survivors told us of particular concerns they had about privacy and confidentiality. Survivors also told us that once they had decided to seek help, they found it difficult to identify appropriate services. We also heard that for many survivors, the services they need are prohibitively expensive.

Second, we discuss issues in relation to mainstream, community support and specialist service responses. We heard that mainstream services have insufficient knowledge of the impacts of child sexual abuse. As a result, we were told that responses can re-traumatise victims and survivors who are seeking help. We heard that specialist expertise is limited and inconsistent. We were also told that services had a limited capacity to respond to the diverse needs of different groups of victims and survivors.

Finally, we discuss structural barriers to effective service provision. We have been told of a number of issues in the workforce, a lack of adequate resourcing and complexities in the policy environment which inhibit effective service provision.

We explore solutions to these issues in Chapter 5, 'Improving service systems for victims and survivors' and Chapter 6, 'National leadership to reduce stigma, promote help-seeking and support good practice'.

## 4.2 Barriers faced by victims and survivors seeking help

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We heard from thousands of survivors of child sexual abuse and their families about the difficulties they have faced in seeking help. These difficulties could arise from the impacts of child sexual abuse and experiences of trauma, from institutional processes and from issues with the advocacy and support and therapeutic treatment service system. In case studies and private sessions, survivors described:

- the stigmatisation of child sexual abuse, leading to shame
- fears of negative responses to disclosure, including not being believed
- a distrust of institutions and authority
- concerns about privacy and confidentiality
- the lack of information about the service environment
- issues associated with the cost of accessing ongoing support.

In some instances, these feelings were based on earlier experiences of harassment or discrimination after disclosing child sexual abuse. These difficulties were closely linked with the barriers to disclosure, discussed in Volume 4, *Identifying and disclosing child sexual abuse*.

### 4.2.1 Stigma and shame

Throughout our inquiry survivors told us of the debilitating effects of shame as a result of the stigma surrounding child sexual abuse. Many survivors told us that this stigma made it more difficult to disclose their childhood sexual abuse or to reach out for therapeutic treatment or other forms of support.

Child sexual abuse often creates a deep sense of shame for victims.<sup>1</sup> This shame can be a continuing theme in the lives of victims and survivors for decades after the abuse took place.<sup>2</sup> Shame about child sexual abuse can prevent disclosure and therefore prevent victims and survivors from seeking help.

In *Case Study 34: The response of Brisbane Grammar School and St Paul's School to allegations of child sexual abuse*, BSG told us that, after a number of years of abuse by his music teacher, Gregory Knight, he disclosed this abuse to the school headmaster, Mr Gilbert Case.<sup>3</sup> BSG said that, in response, he was reprimanded by Mr Case. BSG told us that Mr Case said words to the effect of 'I am extremely disappointed in your behaviour ... You owe a great debt of gratitude to Knight'.<sup>4</sup> BSG described the effects of shame on victims:

Every case of child sexual abuse will have been conducted in secrecy and behind the veils of shame and guilt. Secrecy within the institutions enables the paedophile, allows the abuse to continue, prevents the abuse from being discovered and protects those responsible from being held accountable.<sup>5</sup>

The ‘veils of shame and guilt’ that BSG described can discourage victims and survivors from seeking support. One survivor, ‘Alanna’, told us she had never been comfortable discussing her experiences of childhood sexual abuse, even with professional psychiatrists.<sup>6</sup> ‘I did not want anyone to know this about me. I find the subject disgusting and very literally unspeakable.’<sup>7</sup> Similarly, ‘Rainer’ told us that shame and lack of self-worth prevented him from seeking support for many years:

What I now feel was happening to me was like there was this wall of darkness or shame or guilt holding me back. It gets back to feelings of self-worth, or being not deserving – worthlessness ... That’s part of that legacy of the abuse.<sup>8</sup>

Another survivor ‘Sherrill’, told us she was sexually abused on a Presbyterian-managed mission in Western Australia. She said for more than six decades she had been too ashamed to disclose her experiences of abuse.<sup>9</sup>

*In Case Study 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at the Retta Dixon Home, a number of former residents of the Retta Dixon Home said they did not report the sexual abuse because they felt too ashamed.<sup>10</sup> This precluded victims and survivors from receiving support and meant that perpetrators were not held to account in the criminal justice system. For example, although Ms Lorna Cubillo testified in court about the physical abuse she experienced, she told us she felt ‘too ashamed’ to tell the court or her lawyers about the sexual abuse she suffered from the same person.<sup>11</sup>*

For some victims and survivors, shame was connected to a fear of humiliation if the sexual abuse became public.<sup>12</sup> This fear was sometimes associated with the widely held – but inaccurate – concern that victims of child sexual abuse were likely to go on to become perpetrators of sexual abuse.<sup>13</sup> For others, concerns that disclosing abuse would bring shame to their family or community prevented them from telling anyone.<sup>14</sup> We heard from a parent who told us their son was sexually abused at boarding school describing how the perpetrator used the threat of shame to keep the son from disclosing:

He said that, you know, ‘You must never tell people what’s happened, because that will just bring shame on your parents to think what you’ve done’, and that it was [male victim]’s fault.<sup>15</sup>

Shame can have a particularly debilitating impact in small communities such as regional or remote areas, where it can be difficult for victims and survivors to seek support anonymously.<sup>16</sup> In *Case Study 39: The response of certain football (soccer), cricket and tennis organisations to allegations of child sexual abuse*, Mr Troy Quagliata talked about his experience of being sexually abused as a young boy by the local cricket club coach in rural Queensland.<sup>17</sup> Mr Quagliata described the difficulties he faced living in a small town, trying to overcome his fear of judgment or ridicule and finding support he could trust:

The shame and thoughts of the abuse are with you all the time. You don't know where to look for help. In town, all the schoolteachers live in the community. I didn't feel comfortable talking to them.<sup>18</sup>

#### 4.2.2 Fear or experience of a negative response

Many survivors told us they feared that disclosing the sexual abuse and seeking support would have negative consequences. In many instances, this expectation was founded on experiences of harassment, discrimination and ongoing verbal, physical and sexual abuse following earlier disclosures, often by representatives of the institution in which they were sexually abused.

Survivors told us they feared being disbelieved, being labelled with negative stereotypes or being targeted for retribution by perpetrators. In *Case Study 5: Response of The Salvation Army to child sexual abuse at its boys' homes in New South Wales and Queensland*, Mr Wallace McLeod told us that after he had suffered a nervous breakdown, he did not tell psychologists about the sexual abuse as he feared they would not believe him.<sup>19</sup>

Stigmatising attitudes about the issue of child sexual abuse made many survivors reluctant to speak openly about their experiences.<sup>20</sup> During a private session, 'Julianne' told us that she was unwilling to report the person who abused her even though he had died as she was worried about possible negative reactions.<sup>21</sup> 'I feel scared of being judged, I know that they would just say, "well you were just a slut, you brought it on" ... I know they would.'<sup>22</sup>

Similarly, 'Candice' told us during a private session that after she had been sexually abused by a ministerial servant in her local Jehovah's Witnesses congregation, she was told by the congregation's committee of elders that she was responsible for the abuse.<sup>23</sup> She said that the congregation's attitude towards sexual abuse was generally to conclude that the victim was either mistaken or somehow responsible. Because of this, 'Candice' did not speak about the abuse again for a number of decades until she contacted the Royal Commission.<sup>24</sup>

In another private session, 'Mac' gave us two reasons for not disclosing the sexual abuse or seeking help.<sup>25</sup> First, he said the abuse had occurred in a boys' home run by The Salvation Army, and at the time he was worried that disclosing would jeopardise his relationship with the home. Second, the myth that victims of abuse become perpetrators as they grow up became a powerful barrier that prevented him from disclosing:

The reasons you don't come out with it, it's a lot to do with children, like if you told someone you were molested as a child they might think you are one, and not trust you round their children. You're not, but that's how you think. It's a common thought. It's the reason you don't say anything.<sup>26</sup>

We were told that survivors of child sexual abuse could experience discrimination from service providers.<sup>27</sup> In addition, in submissions to our *Advocacy and support and therapeutic treatment* issues paper, a number of practitioners and service agencies told us that issues of stigma and shame presented a substantial barrier for victims and survivors to overcome before seeking support.<sup>28</sup> Despite this, we were told that the current service system could work to reinforce patterns of stigma. Ms Sylvia Huntington, a private practitioner, noted that survivors of child sexual abuse were often diagnosed with a personality disorder, and argued that 'diagnoses are associated with stigma, blaming the victim, out of date ideas that they cannot be treated, and professional discrimination'.<sup>29</sup>

People with disability faced particular risks when disclosing child sexual abuse or seeking support. Through submissions to our *Advocacy and support and therapeutic treatment services* issues paper, we heard about negative, discriminatory and stigmatising attitudes towards children and adults with disability.<sup>30</sup> Children with Disability Australia told us that people with disability could often be seen as 'incapable, a burden, or objects of pity or charity'.<sup>31</sup> These attitudes could impact on how services responded to allegations or disclosures of child sexual abuse and associated trauma. In some instances, the perpetrator might also have been the victim's carer, or the victim might have relied on the perpetrator in other ways. In addition, a lack of adequate communication supports could inhibit disclosure.<sup>32</sup>

People with disability are sometimes 'referred on' by services that assume a more appropriate support option is available.<sup>33</sup> In a submission to our *Advocacy and support and therapeutic treatment services* issues paper, People with Disability Australia noted that in some instances, service providers refused support to a person with disability, assuming that a more appropriate service would be available elsewhere, which was rarely the case:

[People with Disability Australia] provided support to a counselling service who initially assumed that a legally blind client would be better served by 'disability-specific counselling'. This counselling, of course, does not exist, and the changes to service provision required by this client in order to access the service was basic – simply a matter of not relying on written handouts for 'homework'. These forms of exclusion make life particularly difficult for people with disability who are survivors or victims of child sexual abuse.<sup>34</sup>

Fear of negative responses can inhibit victims and survivors seeking support from specialist sexual assault services as well as from a range of other mainstream service agencies. Addressing these fears requires two avenues of response. First, we should ensure that there are clear pathways for victims and survivors to disclose sexual abuse and seek redress and support, within institutional settings in which the abuse may take place and also within other agencies responding to trauma or related issues. Second, we should challenge the stigma around child sexual abuse, which, as noted, we have been told presents a substantial barrier for victims and survivors to overcome when disclosing sexual abuse and seeking support. These issues are discussed further in Chapters 5 and 6.

### 4.2.3 Distrust of institutions and authority

We heard many stories of inadequate, re-traumatising and sometimes abusive institutional responses to disclosures of child sexual abuse. These responses can have a lasting impact on future help-seeking. Many survivors described their ongoing distrust of institutions and of people in positions of authority. This lack of trust and confidence in institutions is a significant barrier to accessing advocacy and support and therapeutic treatment services. Chapter 4 of Volume 3, *Impacts* details further what we learned about institutional betrayal.

Advocacy and support and therapeutic treatment services are offered by a range of organisations, including those directly or indirectly associated with institutions in which the child sexual abuse occurred. The Care Leavers Australasia Network observed that where support services were being provided by those who had run orphanages, children's homes and foster care in the past, care-leavers could feel as though they were returning to the perpetrator who abused them to get the support they needed.<sup>35</sup>

Submissions to our issues paper on advocacy and support and therapeutic treatment services noted that, due to their experience of government and church-run institutions, victims and survivors may mistrust institutions they encounter in daily life such as government agencies, the justice system and service providers.<sup>36</sup> As explained by Victorian family support organisation drummond street services, survivors could feel they were unable to share their experiences because they had to work with systems they did not trust.<sup>37</sup>

For many Aboriginal and Torres Strait Islander people and communities, the history of government and church involvement in the removal and institutionalisation of children has resulted in mistrust and fear of these services, and a reluctance to engage.<sup>38</sup> Research we commissioned into the service and support needs of specific populations also found that, while some Aboriginal and Torres Strait Islander survivors would prefer to use support services provided by other Aboriginal or Torres Strait Islander workers, others preferred not to see these workers due to concerns about confidentiality.<sup>39</sup> This highlighted the importance of both a skilled Aboriginal and Torres Strait Islander workforce as well as culturally competent workers in mainstream services.<sup>40</sup>

We were often told that survivors perceived the support they received from institutions as insincere.<sup>41</sup> In *Case Study 11: Congregation of Christian Brothers in Western Australia response to child sexual abuse at Castledare Junior Orphanage, St Vincent's Orphanage Clontarf, St Mary's Agricultural School Tardun and Bindoon Farm School*, we heard that although some survivors used the counselling and support arm established by the Christian Brothers, others were concerned about its lack of independence.<sup>42</sup> This is consistent with the findings of research we commissioned.<sup>43</sup>

We heard that some victims tried to draw attention to the sexual abuse and, as a result, were punished or further abused. In *Case Study 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Ms Robin Kitson described how she told a visiting welfare officer she had been abused by other girls in the dormitory at the Parramatta Girls Home. Ms Kitson told us that the officer notified the superintendent of the home, Mr Percival Mayhew, about the abuse. Ms Kitson said Mr Mayhew then struck her in the face with a bunch of keys and sent her to isolation for 21 days.<sup>44</sup> We were told that such responses often destroyed confidence in authorities.<sup>45</sup>

#### 4.2.4 Concerns about privacy and confidentiality

Because of the taboo surrounding child sexual abuse and the feelings of shame and stigma that victims and survivors can experience, being assured of privacy and confidentiality when seeking assistance is essential. Many survivors told us they went to great lengths to ensure that accessing support did not mean the sexual abuse became known in the broader community. This presented particular challenges for victims and survivors living in small regional communities, tight-knit faith-based communities, some culturally and linguistically diverse communities, as well as for some people with disability.

For victims and survivors living in regional and remote areas, we were told that maintaining confidentiality of their information could be challenging as they could have varied, multiple or complex relationships in the community. This could mean local support services – such as medical and justice services – were staffed by friends, relatives or neighbours of the victim or perpetrator.<sup>46</sup> To overcome this, victims and survivors sometimes chose to use services, where available and accessible, outside their local area.<sup>47</sup> During a private session, ‘Samuel John’ told us about the challenges he faced in keeping his story confidential, because of connections between support workers in his local community and family members.<sup>48</sup> ‘I don’t want them to have anything to do with my case.’ Instead, he saw a counsellor in the city, meaning that attending counselling sessions in person took all day. ‘That’s a safer avenue for me.’<sup>49</sup>



In our *Sporting clubs and institutions* case study, BXE told us about his experience of being abused as a boy while living in a small rural town. BXE talked about how living in a small community made it difficult to keep things private:

I think it is harder for kids in smaller towns to report abuse. It hasn't changed much over the years. It was hard for me to report the abuse because everyone knows everyone. It is still the same today. People gossip all the time. If you stand out, people talk about you.<sup>50</sup>

People from small culturally and linguistically diverse communities told us of concerns regarding confidentiality and privacy if they saw a worker from their own community. The small size of some communities could mean survivors were more likely to know authorities or service providers such as interpreters.<sup>51</sup> In our multicultural public forums we were told of concerns that some interpreters could also have conflicts of interest between their professional role and their role in the community, which raised issues about confidentiality.<sup>52</sup>

Research we commissioned identified similar concerns about confidentiality among some Aboriginal and Torres Strait Islander victims and survivors where a worker was connected through family and community networks.<sup>53</sup> In a private session, 'Gina' told us she did not access Aboriginal and Torres Strait Islander-specific services as, due to the small size of the community she lived in, she could not be certain that she could do so confidentially.<sup>54</sup> However, we also heard that some Aboriginal and Torres Strait Islander people preferred Aboriginal and Torres Strait Islander-specific services,<sup>55</sup> were able to disclose sexual abuse for the first time when accessing an Aboriginal and Torres Strait Islander-specific service<sup>56</sup> and received good-quality healthcare and support from an Aboriginal and Torres Strait Islander medical service.<sup>57</sup>

We also heard from victims and survivors about other privacy concerns. In one rural community, Anglicare WA found that some children were uncomfortable about using a community health clinic due to the lack of privacy.<sup>58</sup> In these communities, a lack of public transport could also mean victims and survivors and in particular people with disability had to rely on taxis or family members to get to services, again jeopardising confidentiality.<sup>59</sup>

Victims and survivors could also be reluctant to access therapeutic support because of concerns about who could access – or who might control – their counselling or medical records. In some cases, it could be important for service providers or health professionals to share an individual's medical, counselling or therapeutic information with other institutions or individuals that had responsibilities for the safety and wellbeing of children. For instance, it could be important for a school to be aware of a child's prior trauma in order to be able to support that child. However, given the sensitivity of the information contained in such records, it is important that there are safeguards to protect it from inappropriate use or disclosure. This is discussed further in Volume 8, *Recordkeeping and information sharing*.

## 4.2.5 Lack of information regarding available support

The lack of easily available and accessible information can leave victims, survivors and their families feeling overwhelmed and frustrated when trying to find appropriate services. Research we commissioned identified that secondary victims such as family members find the range of available services difficult to navigate, especially if urgent needs arise after hours.<sup>60</sup> These difficulties can result in victims and survivors not receiving the most appropriate advocacy and support and therapeutic treatment services in a timely manner. One survivor, Mr Matthew Stuart, told us of difficulties he faced identifying available support: 'Where are all these other services and how do you find them? It seems like the system is only set up to deal with crisis situations – when something like a suicide attempt or violence occurs'.<sup>61</sup>

Research we commissioned identified that survivors often had limited knowledge about what services were available to them.<sup>62</sup> Submissions from individual survivors to our issues paper on advocacy and support and therapeutic treatment services confirmed that they were often not made aware of advocacy and support services including survivor support organisations,<sup>63</sup> services for care-leavers,<sup>64</sup> advocacy services,<sup>65</sup> and services for victims experiencing difficulties with child protection agencies.<sup>66</sup> A survey undertaken for Micah Projects showed one of the main reasons Forgotten Australians did not access services designed for Forgotten Australian was that they were unaware of their existence.<sup>67</sup> We also heard that survivors and their carers regularly had to navigate their own pathway to counselling services,<sup>68</sup> leaving them frustrated and unlikely to remain engaged with them. The Canberra Rape Crisis Centre and Service Assisting Male Survivors of Sexual Assault told us that this lack of information could result in victims and survivors not engaging with services at important points in their lives:

There are no services to support survivors of child abuse to find out about and access relevant support other than information on the internet or held by other services, usually in the form of brochures or service databases. As a result, most of our clients access services when they are at a crisis point and some damage to their lives – such as the loss of relationships, loss of employment or accommodation, or criminal charges being laid – has already been sustained.<sup>69</sup>

We heard that some survivors did not make connections between their experience of child sexual abuse and current issues they were dealing with including addiction, relationship breakdown and mental health. In a submission to our *Advocacy and support and therapeutic treatment services* issues paper, one survivor told us that for many years he 'suffered from a lack of self-esteem and confidence, depression and self-loathing, but I had no idea why'.<sup>70</sup> Similarly, 'Andy Trevor' told the Royal Commission that he had only just become aware, through a forensic psychology report, that many of the issues he was facing were related to his childhood experiences of sexual abuse.<sup>71</sup> 'I've been locked up in prison over 30 years, plus the boys' homes, so I couldn't really look outside of the prisons [and] acknowledge that those things

have had a result, you know.’<sup>72</sup> In one research study, survivors of child sexual abuse reported continuously seeking help from services such as drug and alcohol and other welfare services until the links were made either by themselves or a worker between their current issues and their history of child sexual abuse.<sup>73</sup>

#### 4.2.6 Lack of affordable services

We heard from some survivors that accessing appropriate support and therapeutic treatment was prohibitively expensive. Research into survivors’ experiences of support services found that many survivors wanted to have counselling or wanted further counselling sessions but could not afford to pay for these services.<sup>74</sup> We also heard from survivors who were able to access support through particular programs but for whom the maximum amount of support was insufficient.<sup>75</sup>

Several submissions to our issues paper on advocacy and support and therapeutic treatment services noted the high costs to victims and survivors funding their own therapeutic treatment.<sup>76</sup> In his submission, Mr Mark Griffiths, a sexual assault counsellor for male survivors, summed up the issue:

The overall picture is that there is a serious shortage of specific services for survivors of child sexual assault that do not put a significant financial burden on the survivor. This is a significant issue around equity of access to health services for this large group in our community. We know what will help many of them recover but this help is often not available.<sup>77</sup>

Under Medicare, victims may be eligible for up to 10 individual and 10 group allied mental health services per calendar year. Survivors often told us that these sessions were helpful but insufficient.<sup>78</sup> This was discussed in our *Redress and civil litigation* report.<sup>79</sup> Those who were able to continue with long-term therapy acknowledged this was often only possible because they were either working or had other financial means to pay for the treatment. One survivor told us about his choice to bypass the Medicare system:

I have ... chosen to bypass the Medicare system and continue to fund [therapeutic] appointments privately. While this is a large drain on my finances, I find this more agreeable than going through ‘the system’. However, of great concern to me is what happens to those [child sexual abuse] survivors who can neither face ‘the system’ nor afford private sessions – is this the reason many don’t survive?<sup>80</sup>

While mainstream therapeutic treatment such as psychological and psychiatric services are covered under Medicare, we heard that newer treatment modalities such as eye movement desensitisation and reprocessing (EMDR) and mindfulness-based practices generally had no rebate.<sup>81</sup> If survivors wanted to use these services they often had to pay for them themselves, which could make them inaccessible.

We heard about the hidden costs of seeking treatment, including having to fund travel and accommodation or take time off work.<sup>82</sup> One survivor called these the cumulative costs borne by victims.<sup>83</sup> Survivors who lived in areas that lacked services could find the costs and time involved in travelling to services prohibitive.<sup>84</sup>

We heard from service providers of the potential benefits of online services, video counselling and information sharing. However, we also heard that these services were inaccessible to some victims and survivors who may not have the technological skills to use web-based services, who were unable to afford internet connections or who could not access the equipment.<sup>85</sup> This could be compounded for victims and survivors in boarding houses, group homes and other institutions who might have difficulty accessing any technology, even a telephone, or who lacked confidential access to a telephone or computer.<sup>86</sup>

Several survivors told us that they used or planned to use redress or victims of crime compensation payments to fund therapeutic treatment. For example, 'Marius' told us he had seen different counsellors over the years but it had not been easy to find someone with specialised understanding of his particular needs.<sup>87</sup> He finally started seeing someone who helped, but he had to stop because he could no longer afford the appointments. A few years ago 'Marius' reported his childhood sexual abuse to police and he told us he hoped to end up with a compensation payout he could use to return to counselling.<sup>88</sup>

The high cost of services was also recognised as a barrier for secondary victims. Some secondary victims were unable to afford therapy for both themselves and the primary victim. One secondary victim who participated in research we commissioned was forced to cease her own counselling in favour of her son's because she couldn't afford to pay for both:

My counsellor was charging me \$160 a week and I got some back on Medicare ... and I used the 10-week plan but ... after that I couldn't ... it was expensive. I couldn't afford to maintain the counselling for me and for [my son] and you know his needs came before mine.<sup>89</sup>

## 4.3 Mainstream and specialist service responses

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There are many skilled and dedicated practitioners providing advocacy and support and therapeutic treatment to victims and survivors of child sexual abuse. However, through private sessions and submissions to our *Advocacy and support and therapeutic treatment* issues paper we were told that the level of knowledge and expertise available in the mainstream and community-based service sectors relating to recognition and responses to child sexual abuse and providing trauma-informed care was ad hoc and inconsistent. We heard that:

- not all mainstream professionals provided trauma-informed practice
- specialist sexual assault and trauma expertise was limited and inconsistent
- services lacked the necessary skills and knowledge to work with the diverse range of population groups.

### 4.3.1 Knowledge of child sexual abuse and trauma

Victims and survivors of child sexual abuse come into contact with a broad range of agencies and professionals over the course of their lives. If they disclose, they may do so in a variety of contexts.<sup>90</sup> Some may present to services with symptoms related to the effects of child sexual abuse without verbally disclosing.<sup>91</sup> Throughout our inquiry it became evident that many front-line workers who were not from the specialist sexual assault field lacked awareness and skills to recognise presentations consistent with child sexual abuse, and respond appropriately when a victim or survivor disclosed their childhood trauma. We heard of the distress victims and survivors felt as they struggled to deal with ineffective and inappropriate practices in a range of settings. At times, victims and survivors were re-traumatised by their interaction with services, which led some to stop seeking assistance.

We heard of poor responses in a range of service settings. We heard of problems in services ranging from general medical practice to aged care, mental health, allied health, counselling, schools, alcohol and other drug services, disability-specific services, out-of-home care and detention settings. We heard that workers in these services were often untrained about how to respond appropriately to child sexual abuse.<sup>92</sup> The lack of evidence-based practice among mainstream professionals has also been identified in research.<sup>93</sup> We were told that a lack of understanding about child sexual abuse could lead to disclosures being denied, dismissed or downplayed. 'Katie', a survivor, told us in her private session about her first disclosure – to her guidance counsellor in Year 10:

She just basically turned around and said to me, ‘Well you’re lucky you turned out so good. You don’t need to worry about it now. It’s not happening now, it’s all over’. We went on to talk about going on to Year 11 and 12 and what subjects.<sup>94</sup>

Another survivor, ‘Scott James’, told us that when he disclosed to his assigned welfare worker that he’d been sexually abused, he wasn’t believed.<sup>95</sup> ‘I told him a couple of times, but very limited and he dismissed it, so then I never ever said nothing to anyone again until later on.’<sup>96</sup> Another survivor told us about some of the discouraging responses he had had to disclosing his experiences of childhood sexual abuse and seeking help. ‘I have been told, “Life is unfair, just forget about it, put it behind you, move on with your life”.’<sup>97</sup>

We heard that many disability-specific services and staff lacked the requisite knowledge to respond appropriately to child sexual abuse.<sup>98</sup> As with all children, behavioural problems for children with intellectual disability can be an indicator of sexual abuse or, in some circumstances, an attempt to disclose abuse.<sup>99</sup> However, disability organisations told us that disclosures were often dismissed and ‘challenging behaviours’ were often misunderstood as part of the victim’s disability rather than an indication of trauma.<sup>100</sup> Disability services rarely provided support to access specialist sexual assault or trauma counselling.<sup>101</sup> In *Case Study 41: Institutional responses to allegations of the sexual abuse of children with disability* we heard from the CEO of a disability service provider in New South Wales that her organisation did not offer any counselling, assistance or other services after a child with disability disclosed that he had been sexually abused because the organisation believed better access to specialist services would be offered through other agencies.<sup>102</sup>

We received a large number of submissions to our issues paper on advocacy and support and therapeutic treatment services. Many of these focused on detrimental practices in front-line services. We heard that agencies and professionals were often unaware of good practice for supporting victims and survivors,<sup>103</sup> and that these agencies and professionals often emphasised problems with the victim rather than with the perpetrators or acts of abuse.<sup>104</sup> In addition, we were told of instances where agencies blamed victims and survivors for the sexual abuse,<sup>105</sup> did not tell victims and survivors that recovery was possible,<sup>106</sup> did not recognise the grooming process<sup>107</sup> and did not recognise certain behaviours of victims as attempts at self-regulation.<sup>108</sup> We heard of services asking naive questions of victims<sup>109</sup> and either inappropriately focusing on details of the abuse without discussing the possibility of recovery, or avoiding direct discussion of the trauma entirely.<sup>110</sup>

We heard that some professionals specifically chose not to ask a client about possible childhood sexual abuse as they did not know how to respond.<sup>111</sup> Research into this issue suggests a range of reasons why clinicians in certain settings do not ask about histories of abuse, including: not wanting to be intrusive or inappropriate; not identifying a connection between the presenting problems and child sexual abuse; a belief that there were more immediate needs; a lack of time and resources; a fear of vicarious traumatising; a concern about causing distress to clients; and a fear of inducing ‘false memories’.<sup>112</sup>

Victims and survivors often needed to access a number of support services to address the entire range of their needs. This can be an important step but, when done poorly, can re-traumatise victims and survivors. One victim described how having to tell her story to multiple service providers was traumatic:

If I choose to seek assistance from a psychologist, I have to tell my story again. You know, it's just, 'We're just going to keep victimising and we're going to victimise you again and we're going to make you tell it all again'.<sup>113</sup>

Some stakeholders from other service sectors told us they were not equipped to recognise and respond to child sexual abuse and trauma. In public multicultural forums we held throughout the country, we were told the majority of staff in multicultural organisations were not trained to respond adequately and effectively to child sexual abuse concerns.<sup>114</sup> In addition, as with many mainstream services, many culturally based organisations were reluctant to talk about sexual assault, which meant clients would not receive referrals to specialist services that could have been helpful.<sup>115</sup> Many submissions to our issues paper on advocacy and support and therapeutic treatment services<sup>116</sup> – as well as participants in our public multicultural forums<sup>117</sup> – noted that interpreters were often not trained in issues related to sexual abuse. This limited their ability to provide an effective service to victims and survivors.

Although victims and survivors used a range of services, the mental health sector was identified – in submissions,<sup>118</sup> private sessions<sup>119</sup> and at our private roundtable on advocacy and support and therapeutic treatment<sup>120</sup> – as a key service that victims and survivors used, but one that often did not provide an adequate response to their disclosure. We were told that the response by the mental health system to victims and survivors of child sexual abuse often remained focused on a mental health diagnosis.<sup>121</sup> This could lead to underlying trauma being overlooked, with treatment focusing instead on presenting symptoms such as depression.

'Toni' told us about her experiences trying to find appropriate mental health services.<sup>122</sup> She explained she was once involuntarily placed in a mental health facility after taking an overdose. Despite recognising the significance of her experience of child sexual abuse, she said the practitioner at the mental health facility was not interested in discussing the abuse, focusing instead on the circumstances immediately preceding the overdose.<sup>123</sup>

'Calvin Michael' told us that his memories and distress about being sexually abused resurfaced in times of stress.<sup>124</sup> This occurred when he was upset by a significant health scare in his forties, but his attempt to speak to his psychiatrist about his childhood trauma was dismissed:

I remember going to a psychiatrist then, and bringing up this factor of my experience of sexual abuse, and he dismissed it. Now I'm amazed ... I was a bit surprised that this person would dismiss that when I brought it up.<sup>125</sup>



A mother of one victim who suicided told the Royal Commission that trauma-informed care was needed. 'I now realise my daughter didn't get the right therapy though she saw many psychiatrists.'<sup>126</sup>

## Detention settings

Throughout our inquiry we heard that youth justice and adult prison settings can be particularly difficult for survivors, as they increased the risk of re-traumatisation and raised particular barriers to accessing appropriate therapeutic treatment.

In our consultation processes we heard that living in close proximity to other people who were likely to have significant trauma, undergoing prison processes such as body searches and living with the risks of being assaulted in prison could all perpetuate feelings of instability and insecurity in victims and survivors, potentially re-traumatising them.<sup>127</sup> A 2008 literature review of clinical practice on creating 'trauma-informed correctional care' described the re-traumatising effect prison could have for victims and survivors of trauma:

Prisons are challenging settings for trauma informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loudspeakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat-downs and strip searches, frequent discipline from authority figures, and restricted movement ... This is likely to increase trauma-related behaviours and symptoms that can be difficult for prison staff to manage ...<sup>128</sup>

Service agencies who worked with the Royal Commission's Queensland Inmate Engagement Strategy told us they were concerned about a lack of trauma screening and 'overall lack of a trauma-informed corrective services system'.<sup>129</sup> During our consultation with children and young people in youth detention we were told that management of disclosures or concerns from children and young people in youth detention was poor and sometimes included the use of restraint and other re-traumatising practices in response to incidences of self-harm.<sup>130</sup> Counsellors in youth detention settings told us of a culture where, in their view, staff – particularly guards – treated the children and young people as criminals, with some staff expressing the belief that children in detention were using their trauma as an excuse for bad behaviour.<sup>131</sup> We also heard how disclosures of sexual assault that took place prior to coming into custody were often inappropriately handled.<sup>132</sup>

Several submissions to our *Advocacy and support and therapeutic treatment services* issues paper noted that the range of service options provided for survivors in detention facilities is limited.<sup>133</sup> The Victorian Centres Against Sexual Assault told us that they receive regular requests to provide sexual assault counselling services to correctional facilities for men, but that there are no funds available to support this. As a result, they provide very limited services to male survivors in prisons.<sup>134</sup>

For victims and survivors who want to seek help within detention settings, we were told that privacy and confidentiality is important.<sup>135</sup> Multiple submissions to our issues paper concerning advocacy and support and therapeutic treatment services noted lack of privacy and confidentiality as a significant barrier to accessing services in detention environments.<sup>136</sup> Victorian Centres Against Sexual Assault described how limited privacy within the detention environment meant survivors were less likely to seek sexual assault counselling:

In prison, the women's movements are closely monitored. Every time a client attends any service it can become public knowledge among correctional officers, clinical services, and in some cases, other prisoners. In response to living in the prison environment, potential clients may not seek sexual assault counselling in an effort to keep her/his matter private and to have some sense of power over her/his life. It is well researched and documented knowledge that the impacts of sexual assault can trigger a shame response for survivors; therefore, some people may avoid accessing sexual assault counselling to maintain privacy. In men's prisons, being identified as a victim of sexual assault can increase risk of further assault.<sup>137</sup>

We heard that survivors in detention settings may also face significant difficulties receiving support when transitioning out of detention.<sup>138</sup> One survivor, 'Nik', told us about his experience of inconsistent services while he was in prison, as well as after he was released.<sup>139</sup>

## **‘Nik’**

‘Nik’ grew up on the south coast of New South Wales in the 1980s. His father was jailed for domestic violence when ‘Nik’ was about 10 or 11 years old, after the children witnessed their mother being brutally bashed. ‘Nik’ remembers the police being involved in the family’s life from very early on. Child protection services attempted to make him a ward of the state, but his mother resisted and he stayed with the family. There was no ongoing coordinated support or rehabilitation for ‘Nik’ or his family, despite him being identified by child protection as being at risk.

‘Nik’ said that from about age 10 or 11, he ‘went off the rails’, committing breaking and entering offences and stealing cars. By the time he was 12, ‘Nik’ was being shunted between various youth detention facilities, where, he told us, he experienced brutal physical and sexual abuse. He became addicted to illicit drugs and alcohol and left school in Year 8. During all this upheaval, ‘Nik’ was not offered any social, emotional or educational support. Since he turned 18, ‘Nik’ has been in and out of the adult prison system.

The impacts of his childhood sexual abuse and incarceration include an interrupted education and working life, dislocated family relationships, panic attacks, and a deep-seated mistrust of people in authority.

Being regularly moved from prison to prison without notice had a destabilising effect that further entrenched ‘Nik’s’ anxiety. He said his periodic exposure to different psychiatrists in the prison system has been fractured, leaving him feeling ‘more fucked up’.

‘Nik’ is currently linked in with knowmore, a free legal advice service for people who engage with the Royal Commission. They are helping him with a compensation case, and have organised four free counselling sessions by a private provider, which ‘Nik’ feels is completely insufficient and will do nothing to help him. The Royal Commission has subsequently referred him to a service that can provide many more sessions in prison and after he is released.

When he is released from prison, ‘Nik’ told us he will need ongoing psychological support, income support and assistance with housing and employment. He cannot access these agencies while he is in prison, and on release the pressures of learning to adjust to life on the outside could interfere with him successfully navigating the support service system on his own. He does not have a case manager to consider his varied needs holistically.<sup>140</sup>

We learned about the experiences of victims and survivors in adult detention environments through the Royal Commission prisoner engagement strategy. The strategy, which is explained in more detail in Volume 5, *Private sessions*, involved Royal Commission officers working with staff and prisoner representatives within correctional centres to enable Commissioners to hold face-to-face private sessions in prisons across Australia. As part of the strategy, the Royal Commission established processes to ensure, where appropriate, referrals were made to psychological support services within prisons as well as external counselling and legal support services. Royal Commission staff also conducted presentations to uniformed and non-uniformed prison staff on trauma-informed practice, to assist them in managing and responding to prisoners' experiences of child sexual abuse. Our work in detention environments suggests that a substantial number of survivors who are in detention settings are willing to take up therapeutic treatment when it is made available. For example, we were told that the Royal Commission's work in detention settings in Queensland resulted in a large number of requests for referrals to counselling services.<sup>141</sup>

## Aged care settings

Throughout our inquiry we heard that aged care settings can be re-traumatising for older survivors. The aged care environment can replicate features of institutions in which some survivors were sexually abused, including dependency and control, institutional routines, reduced privacy and isolation. We heard about a lack of appropriate advocacy and support and therapeutic treatment services available to older survivors living in aged care facilities, and that staff did not have appropriate knowledge and skills to respond to their potential needs.

Several older survivors told us in private sessions they were distrustful and fearful of aged care institutions because either the physical care they received triggered memories of the sexual abuse that they said had occurred during their childhood, or the environment reminded them of the institution where the abuse occurred.<sup>142</sup>

### **'Naomi'**

Recent health problems led to 'Naomi' being housed temporarily in an aged care facility. Her life had been transient for decades and, she said, staff didn't appreciate her difficulty in being contained within four walls. 'Naomi' told us that it would be good if staff from government, care and community services organisations could become more 'trauma-informed'. 'They need people who can support us at the end of our time because we go into our shells. We get scared. I've run away from the nursing home a couple of times because in my head it was like being back in that home, and they don't understand. They just don't understand.'<sup>143</sup>

Submissions to our issues paper on advocacy and support and therapeutic treatment services raised the need for training to help staff provide appropriate responses to survivors in aged care.<sup>144</sup> We heard that training was important to respond to the large number of care-leavers – many of whom are survivors of sexual abuse – who are entering aged care facilities,<sup>145</sup> as well as the possibility of disclosure later in life.<sup>146</sup> In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse)*, Dr Philomena Horsley, Research Fellow at La Trobe University, described this gap in staff competency:

The staff of prisons, aged-care facilities and disability organisations are often undereducated, they're underpaid and often there is understaffing, and so the ability to actually have a whole-of-service education program around the impacts of trauma that residents have lived with has been really limited ...<sup>147</sup>

Dr Horsley noted that in some aged care settings there is no process whereby survivors can safely disclose sexual abuse and have their disclosure respected and treated with care and support.<sup>148</sup> We also heard from Ms Karyn Walsh, CEO of not-for-profit service provider Micah Projects, who said her organisation is hearing from many older people who wish to disclose.<sup>149</sup> She emphasised the inadequate understanding of the needs and sensitivities of survivors in the aged care service system, and the potential for re-traumatisation:

it has been those intergenerational conversations that people have had that have sometimes triggered them to think about, 'Well, that's what I experienced', and certainly care, and aged care, and losing control of their sense of physical control, not having to tell everybody what they've been through and why they shouldn't be touching them without talking to them first, all those really basic things are things that right across the service systems that we've got to integrate and not think we've got to create another system that fragments people off, if you've experienced childhood sexual abuse and you're ageing.<sup>150</sup>

In a research study on the life experiences and support needs of Forgotten Australians, Child Migrants and members of the Stolen Generations, many participants stated that they were in need of ongoing counselling and specialist psychiatric assistance to address the long-term mental health impacts of trauma associated with the abuse, including sexual abuse, they experienced while in care.<sup>151</sup> Many reported that public mental health access provisions available to them were inadequate or inappropriate.<sup>152</sup> The report recommends trauma-informed training for medical and allied health professionals, community services workers and others working with care-leavers, noting training should place emphasis on the effects of institutional sexual abuse. The report also recommended that suitably trained people with lived experience of childhood institutionalisation should be engaged to conduct both training and awareness raising in the aged care sector.<sup>153</sup>

In our consultation processes, service providers told us that victims and survivors should receive government-funded, priority access to specialised aged care services to assist with the impacts of institutional child sexual abuse.<sup>154</sup> We also heard about the need to consider alternatives to residential aged care for care-leavers who do not want to re-enter an institutional setting, including support to remain living in their own homes<sup>155</sup> or other supported accommodation services in non-institutional settings.<sup>156</sup>

### 4.3.2 Access to specialist expertise

Specialist sexual assault services should be available to provide survivors with high-quality, trauma-informed specialist therapeutic treatment.<sup>157</sup> The mother of a man who was sexually abused and subsequently died by suicide told us about the importance of skilled therapeutic treatment: ‘We all desperately need high-quality therapy. I have had two sessions with a local provider but I have felt as if the person has no understanding of my horrendous trauma and grief’.<sup>158</sup>

A range of peak bodies and services working with victims and survivors informed us that existing specialist sexual assault services had insufficient capacity to meet overall demand and there were gaps in provision of support to certain groups.<sup>159</sup> People with Disability Australia highlighted a lack of services able to provide specialist sexual assault therapy to people with disability, especially those with cognitive or communication impairments.<sup>160</sup> Other stakeholders told us many services were not appropriate for the needs of men.<sup>161</sup>

In private sessions, survivors told us it was not easy to identify which services offered high-quality, specialist trauma therapy. We were told on many occasions that survivors had accessed services advertising specialist support, only to find they were inappropriate for their needs. ‘Bridget Ann’ told us that after her first counsellor, she had difficulty finding other therapists who understood her situation and needs.<sup>162</sup> She said that after a few sessions, she would find herself telling them, ‘I have a feeling that you’re getting more out of these sessions than I am ... Well I’m sorry, I’m not here to educate you’.<sup>163</sup>

Service providers at our private roundtable on advocacy and support and therapeutic treatment indicated that, even within specialist sexual assault services, some practitioners had insufficient knowledge of the history of institutional abuse in Australia, including the trauma, loss of identity and feelings of mistrust and abandonment that many survivors experienced.<sup>164</sup>

In a submission to our issues paper on advocacy and support and therapeutic treatment services, a survivor, Mr Michael Collins, expressed his concerns about the lack of expertise in the sector:

Many paid professionals enter our lives coming straight from the academia at university. Many more have trained in fields of study that bear no relationship with the challenges that service user[s] face. I was recently dismayed when I was told that all workers of a service provider were thought to be quite qualified to act as counsellors in the eyes of management.<sup>165</sup>

Workforce issues are exacerbated within smaller communities. Specialist practitioners are frequently unavailable in regional and remote areas.<sup>166</sup> We were told of extremely high staff turnover rates in regional and remote Australia.<sup>167</sup> Only around 12 per cent of psychiatrists and 18 per cent of psychologists practice outside the major cities.<sup>168</sup> Regional and remote sexual assault services also often struggle to find qualified local staff or attract and retain staff from outside the community.<sup>169</sup> Practitioners told us that this situation was caused by a range of factors including inadequate funding, isolation and lack of available professional development.<sup>170</sup>

Where specialist support was available, we heard that victims and survivors could face long waiting times to see a sexual assault worker. Research we commissioned to look into pathways to support survivors and their families found that waiting periods or waiting lists could act as a barrier to those seeking help. Long waiting times may also indicate a level of demand that the specialist assault services were unable to meet.<sup>171</sup> We heard directly from sexual assault services in Victoria of waiting lists ranging from three to 12 months.<sup>172</sup> The NSW Ombudsman reported that some child and adolescent sexual assault services in that state had waiting lists of two years.<sup>173</sup>

Waiting periods may be influenced by the sexual assault services prioritising recent survivors of sexual assault over those disclosing years after the event. The NSW Health Sexual Assault Service Policy and Procedure Manual lists seven client groups to prioritise for counselling services. In this list, adult survivors of childhood sexual assault are the lowest priority.<sup>174</sup> The NSW Ombudsman noted in a submission to us that being on this list did not guarantee a service, since many sexual assault services in New South Wales report they rarely work with adult survivors due to limited capacity.<sup>175</sup>



### 4.3.3 Knowledge and skills to respond to all victims and survivors

Victims and survivors of child sexual abuse are diverse. They experience and cope with the abuse in the context of a range of factors such as age, geographical location, gender, faith, culture, disability and sexuality. We heard that both mainstream service agencies and specialist sexual assault services frequently lacked the knowledge and approaches to respond to the diversity of their clients in ways that were culturally safe and relevant to their needs. This has also been highlighted in several recent royal commissions and other inquiries.<sup>176</sup>

#### Victims and survivors with disability

During our inquiry, disability organisations highlighted the general lack of services for people with disability who had experienced sexual abuse.<sup>177</sup> We were told of a disparity between the levels of competence in specialist sexual assault services and mainstream services delivering support to people with disability, and disability services responding to victims and survivors of child sexual abuse.<sup>178</sup> We commissioned a review of research into the service and support needs of specific population groups, including people with disability.<sup>179</sup> This review identified that victims and survivors of child sexual abuse with disability found that disability services do not have the capacity or expertise to respond to issues of interpersonal violence, while therapeutic treatment for child sexual abuse was not specifically adapted to their needs.<sup>180</sup> We were told that this was especially problematic for victims and survivors with intellectual disability.<sup>181</sup> We also heard that there were not enough specialist sexual assault or trauma counsellors experienced in working with people with complex communication or behaviour support needs.<sup>182</sup> There were also few services available to victims with disability in correctional facilities.<sup>183</sup>

We heard from a number of providers about the challenges in balancing disability support needs with therapeutic needs associated with trauma:

Accessing therapeutic treatment services for children and young people with disability who have experienced sexual abuse is typically very problematic. In many areas services simply are not available. Often when services exist, providers often believe that they do not have relevant expertise and that people with disability, including children and young people, will be better served by attending a disability-specific service.<sup>184</sup>

These challenges can result in victims with disability being caught between services without receiving support.<sup>185</sup> In research we commissioned into this issue, the mother of a victim explained how the counsellor they were referred to by the institution where the abuse occurred dismissed her son's need for therapy due to his disability: 'And that's what makes me angry, because when I went there they just looked at him like he's a [disabled] child, so he does not need the counselling ... He never got counselling'.<sup>186</sup>

The lack of adequate trauma training for mainstream services led to victims and survivors with disability being refused access to services.<sup>187</sup> We have been told of widely-held but ill-informed views that children with intellectual disability do not understand and are not impacted by sexual abuse. These views can prevent victims and survivors from accessing support.<sup>188</sup> Additionally, mainstream and disability support services are often inadequately trauma-informed. Inappropriate comments made by service staff could discourage victims and survivors with disability from pursuing those services in the future.<sup>189</sup>

## Aboriginal and Torres Strait Islander victims and survivors

Many Aboriginal and Torres Strait Islander survivors who attended private sessions told us they had received no formal counselling or therapeutic support. Some did not feel culturally safe in services that were not Aboriginal-specific. However, it should be noted that a few survivors told us they did not feel safe in Aboriginal-specific services due to concerns about confidentiality. Some Aboriginal and Torres Strait Islander people found that mainstream services provided temporary solutions that suppressed their symptoms but neglected to address the causes of the trauma.<sup>190</sup> The Victorian Aboriginal Child Care Agency stressed that many of its clients expressed discontent with mainstream counselling services that were not meeting their needs.<sup>191</sup> This was often due to practitioners not appreciating the impact of the systemic displacement of Aboriginal and Torres Strait Islander peoples, both historically and in a contemporary context.<sup>192</sup>

We heard that many Western approaches did not take into account Aboriginal and Torres Strait Islander cultural practices. One survivor told us about her experience of mainstream services:

Many current Western models used by general medicine, psychiatry, psychology and mental health when working with many individuals diagnosed with ‘mental health issues’ do not meet victims’ needs. They often focus on first-order change, dealing with the symptoms not the cause. This was my experience. There was nothing about dealing with intergenerational traumatic events for Aboriginal and Torres Strait Islander victims, nor do they generally reflect or respect cultural faith, beliefs or practices.<sup>193</sup>

We heard that there is a shortage of both culturally appropriate mainstream services and specialist Aboriginal and Torres Strait Islander services for victims and survivors of child sexual abuse.<sup>194</sup> There were also few Aboriginal or Torres Strait Islander professionals working in therapeutic services.<sup>195</sup>

Many Aboriginal and Torres Strait Islander people used mainstream services to get the support they needed. While some Aboriginal and Torres Strait Islander survivors preferred to access the broader service system, they sometimes found that organisations did not approach Aboriginal and Torres Strait Islander clients in a culturally secure way.<sup>196</sup>

Aboriginal and Torres Strait Islander children are significantly over-represented in out-of-home care and youth detention settings, and have higher rates of severe disability than other children.<sup>197</sup> A lack of cultural safety in many of these institutions can compound the risk of sexual abuse and prevent survivors from seeking support.

## Victims and survivors from culturally and linguistically diverse backgrounds

Specialist and mainstream services highlighted the difficulties of helping victims and survivors of child sexual abuse from culturally and linguistically diverse communities.<sup>198</sup> We heard that many practitioners were not sufficiently culturally competent to respond effectively to the needs of victims and survivors with culturally diverse backgrounds. Research suggests that a desire to maintain cultural sensitivity, while important,<sup>199</sup> can lead to ‘professional paralysis’ when responding to clients from culturally and linguistically diverse backgrounds.<sup>200</sup> In addition, some women of culturally and linguistically diverse backgrounds may experience racism and discrimination from workers in agencies.<sup>201</sup>

In our multicultural public forums, participants told us that the vast majority of staff in multicultural organisations were not trained to respond to child sexual abuse concerns, and when they were trained, the service referral pathways were unclear.<sup>202</sup> Conditions within funding contracts for services were seen as especially prohibitive, particularly when they restricted the services’ ability to run community education or development programs:

We have three workers at our specialist sexual assault clinic and a two-year waiting list ... it’s the funding and funding conditions which have restricted us from doing any community education ... when resources are eroding it’s a difficult environment to work in and deal with clients with complex trauma at the same time.<sup>203</sup>

We also heard through our consultation processes about the lack of interpreters with adequate knowledge and skills to work with victims and survivors of child sexual abuse. In a submission to our issues paper on advocacy and support and therapeutic treatment services, Anglicare Australia told us that while providing information in multiple languages could make it easier for victims and survivors to access services, simply translating information was not sufficient – the information itself needed to be culturally appropriate.<sup>204</sup> Participants at the multicultural public forums talked about the need for a better understanding among language interpreters of what constituted child sexual abuse, as well as an ability to culturally interpret the victims’ and survivors’ comments.<sup>205</sup>

## Children and young people

Although there is variation between jurisdictions, we were told that there are limited therapeutic treatment services available to children who have experienced sexual abuse.<sup>206</sup> This means the few organisations that do cater for children and young people often have substantial waiting lists. Submissions to our *Advocacy and support and therapeutic treatment services* issues paper told us that these long waiting lists make it more difficult for services to respond promptly.<sup>207</sup> This may lead to a sense of hopelessness and disempowerment for victims and their families, particularly in instances where child victims have developed problematic coping behaviours.<sup>208</sup>

Specialist child sexual assault service The Gatehouse Centre told us that a lack of funding can limit service providers' ability to attract staff who are appropriately skilled for this work, especially in rural areas. It noted that the pool of clinicians with expertise in working with young children is particularly limited, making it even more difficult to recruit and retain skilled staff.<sup>209</sup>

In our consultations with children and young people, we heard that mental health and other services can be difficult to access when most needed, particularly in areas where no services are located or if the service is difficult to reach using public transport.<sup>210</sup>

We also heard about barriers to accessing support services through schools. Some children and young people told us that they did not feel comfortable talking to their school counsellor, preferring to approach a teacher or peer for help.<sup>211</sup> Others explained that the fear of being found out and ridiculed by other students can act as a barrier to them approaching counselling services within the school.<sup>212</sup> They suggested these services should be privately available.<sup>213</sup>

Multiple submissions to *Issues paper 9: Addressing the risk of child sexual abuse in primary and secondary schools* said that the responsibility for treatment and intervention for victims and survivors of sexual abuse in educational settings should not rest with school personnel alone, as schools could not be expected to have the high level of expertise required.<sup>214</sup> Dr Kerryann Walsh, Associate Professor in the Faculty of Education at Queensland University of Technology, noted it would be more appropriate for schools to access high-quality, specialist, community-based sexual abuse treatment services, with the collaboration and support of school psychologist and counsellors where appropriate.<sup>215</sup> The Royal Australian and New Zealand College of Psychiatrists said that the role of schools in providing support to victims and survivors should be to collaborate with, and increase accessibility to, external treatment services such as child and youth mental health services.<sup>216</sup>

In its submission to our *Advocacy and support and therapeutic treatment services* issues paper, the CREATE Foundation, the national peak body for children and young people who have been in out-of-home care, told us that poor resourcing and a lack of support for carers and workers in out-of-home care systems can negatively affect mental health outcomes for children and young people in care.<sup>217</sup> It also noted that in some jurisdictions individual advocacy services are not available to children and young people who want to address an issue with their out-of-home care placement.<sup>218</sup>

As discussed in Volume 12, *Contemporary out-of-home care*, we know that children placed in out-of-home care may well have already experienced severe abuse and neglect. Children who are sexually abused while in out-of-home care are more likely to experience cumulative harm and complex trauma. We were told that services for these children often do not understand the factors that can have a significant impact on the mental health of children and young people who are, or have been, in out-of-home care.<sup>219</sup> We were also told that the transition from care can be particularly difficult for a child or young person and possibly require extra therapeutic support. We also heard that there is a lack of treatment and support options for young people who are transitioning from adolescent to adult mental health services.<sup>220</sup>

## Male victims and survivors

Sexual assault services have recognised that gender issues must be taken into account when responding to victims and survivors.<sup>221</sup> While some experiences and impacts are similar, there are also significant differences in the needs of male and female victims and survivors of child sexual abuse.<sup>222</sup>

In 2012 the Australian Centre for the Study of Sexual Assault noted that ‘availability of services to assist men sexually abused in childhood is currently fragmented’<sup>223</sup> with access and quality of the services for men differing between states and territories, depending on practitioners’ interest. During our inquiry we heard there is insufficient capacity in the service system to respond to adult survivors in general, and there is a need to enhance support for men. We heard concerns that health and human services staff were often unprepared for disclosures of child sexual abuse from men and could lack the capacity and skills to respond effectively.<sup>224</sup> In the *Nature, cause and impact of child sexual abuse* case study, Dr Gary Foster told us that some sexual assault services are funded for women only.<sup>225</sup> Additionally we have been told that, due to the predominant recruitment of female staff and a perception that sexual assault services are designed for women, there are insufficient numbers of male workers in sexual assault services.<sup>226</sup> Consideration of men’s and women’s differing needs is necessary within an effective service system.

## Victims and survivors who identify as lesbian, gay, bisexual or transgender

We were told about the particular barriers to disclosing child sexual abuse and seeking support faced by victims and survivors who identify as lesbian, gay, bisexual or transgender. In private sessions, we heard that lesbian, gay, bisexual and transgender survivors can experience stigma associated with child sexual abuse as well as homophobia or transphobia.<sup>227</sup> This has been described in research as ‘the doubly silencing effects’ of stigma.<sup>228</sup> In our *Nature, cause and impact of child sexual abuse* case study, Dr Philomena Horsley told us of the ‘significant levels of shame, significant levels of invisibility, keeping a low profile, and much greater levels of sexual violence and other forms of abuse, including discrimination’<sup>229</sup> of victims and survivors who identify as lesbian, gay, bisexual or transgender:

That kind of picture creates issues in terms of whether or not that population group will access services, not just because of the sexual violence but because of their own sexual identity or gender identity.<sup>230</sup>

The Victorian Commissioner for Children and Young People told us in response to our *Advocacy and support and therapeutic treatment services* issues paper that services should be inclusive and ensure survivors do not experience 'a homophobic or heterosexist response'.<sup>231</sup> The Commissioner reinforced the importance of confidentiality as young people may be concerned that accessing support will result in unwanted disclosure of their sexuality to friends and family.<sup>232</sup>

We were told through our consultation processes that the support service needs of survivors in these communities were not being met.<sup>233</sup> This is consistent with broader service gaps identified for lesbian, gay, bisexual and transgender clients in other sectors including health<sup>234</sup> and mental health.<sup>235</sup> In our *Nature, cause and impact of child sexual abuse* case study, we also heard from Ms Penny Rose, a transgender woman who is a survivor of child sexual abuse. Ms Rose told us:

I strongly feel that gender/sexuality diversity training needs to be implemented in all levels of our society. It is through education that ignorance and bigotry surrounding these issues is eradicated.<sup>236</sup>

Information from the *Nature, cause and impact of child sexual abuse* case study, private sessions and current research supports the view that marginalisation and a lack of understanding in the service system may act as a barrier to effective support for lesbian, gay, bisexual and transgender victims and survivors of child sexual abuse.

## Secondary victims

There are no dedicated advocacy and support and therapeutic treatment services for secondary victims of child sexual abuse. Research we commissioned into this issue identified the difficulties that exist for secondary victims attempting to access appropriate and timely information and support.<sup>237</sup> Secondary victims often had trouble knowing where to access support and even when pathways were clear, services were often difficult to access, unhelpful or irrelevant.<sup>238</sup> Agencies were unsure how to respond to needs, making available services patchy and inconsistent.<sup>239</sup> We were told secondary victims found it difficult to be recognised as requiring support, as most services and professionals focused on supporting the primary victim. Where the needs of secondary victims were acknowledged, access to services could be limited to family members, to the exclusion of other secondary victims.<sup>240</sup> This could leave a gap in service provision for other people who have been indirectly affected by child sexual abuse.

## 4.4 Structural barriers to effective service provision

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A number of structural issues in both the mainstream and specialist sexual assault service sectors present barriers to appropriate and effective service provision for victims and survivors of child sexual abuse. These structural issues include:

- workforce issues, including inconsistent practice standards, inconsistent education and professional development, and limited staff support and supervision
- limited resourcing, leading to issues in service provision
- complexities within and between service systems, leading to barriers at the interface between different services.

### 4.4.1 Workforce issues

Many service providers told us that workforce issues impeded effective service provision. A lack of standards and guidelines has led to inconsistent practice and a lack of accountability across both mainstream and specialist services. We heard there were shortcomings in the education, training and professional development of professionals in the field. We have also heard that there is limited scope for staff support and supervision in the sector.

#### Practice guidelines

We heard of inconsistent practice between services due to a lack of knowledge and experience in responding to the needs of victims and survivors of child sexual abuse. Research has identified a lack of national practice guidelines for the sexual assault service sector.<sup>241</sup> Some services recommended that funding be tied to practice standards.<sup>242</sup>

The Royal Commission sought advice from specialist and mainstream services providing support to survivors of child sexual abuse regarding appropriate practice principles. In submissions to our issues paper on advocacy and support and therapeutic treatment services, many agencies<sup>243</sup> endorsed guidelines published by the Blue Knot Foundation: *Practice guidelines for treatment of complex trauma and trauma-informed care and service delivery*.<sup>244</sup> These guidelines help health and human service providers to conceptualise and respond to trauma in their practice, and are particularly important for mainstream agencies and non-specialist staff in specialist sexual assault services.



Other sets of standards discuss best practice for working with victims and survivors of child sexual abuse. The National Association of Services Against Sexual Violence published *Standards of practice manual for services against sexual violence*<sup>245</sup> and Victims Services, NSW Department of Justice published *Good practice in providing services: Victims of sexual assault*<sup>246</sup> as well as *Good practice in providing services: Victims of child abuse*.<sup>247</sup> The extent of their implementation across the range of services is unknown.

We were also told that guidelines for working with families, including ‘trauma-focussed practice’, had been disseminated but not systemically targeted at sexual assault services.<sup>248</sup> The Commission for Children and Young People in Victoria further highlighted the lack of guidelines for staff in youth detention on how to respond to disclosures of child sexual abuse.<sup>249</sup> Phoenix Australia – Centre for Post-traumatic Mental Health argued for the systematic implementation of national guidelines across sectors to address inconsistencies in the assessment of risk in specialist sexual assault, mental health and general support services.<sup>250</sup>

## Accessible education and training

Throughout our consultation processes we were told about the systemic lack of education and training on child sexual abuse and trauma-informed care. High-quality, accessible and nationally consistent professional education and training were often not available or were too costly and time-intensive for staff to undertake.

We heard of:

- limited and inconsistent training
- the tertiary sector inadequately equipping mainstream practitioners with the skills and knowledge to provide trauma-informed care, and inadequately preparing specialist professionals to work with victims of child sexual abuse
- services having limited resources to provide for the training and education of their staff.

We heard that training and professional support for practitioners was limited and inconsistent across Australia.<sup>251</sup> Despite the existence of various national, state and territory education courses on child sexual abuse and trauma-informed care and practice, participants at our private roundtable on advocacy and support and therapeutic treatment identified there was a further need for:

- nationally accredited training for the different skill levels expected and required of staff
- mandatory trauma-informed training for generalist services with attached standards
- training that is open to new and emerging therapies based on promising practice and conceptual evidence

- training for different skill levels and staff such as general practitioners, nurses, reception staff, counsellors and Aboriginal and Torres Strait Islander health workers
- training for management teams to support workers.<sup>252</sup>

We were told that many university programs did not adequately focus on trauma.<sup>253</sup> We heard that many professionals graduated with only a limited understanding of child sexual abuse and trauma because undergraduate programs did not adequately address these issues as part of their core curricula.<sup>254</sup>

We also heard that health, mental health and social work professionals were inadequately trained in appropriate responses to trauma.<sup>255</sup> As a result, victims who presented to mental health services were sometimes not assessed for adverse life experiences. The Children in State Care Commission of Inquiry in South Australia found that there was limited ongoing training for social workers specifically related to child sexual abuse and that what was available was not mandatory.<sup>256</sup> We heard that inadequate trauma training could lead to some survivors such as those with disability being refused access to services due to a lack of understanding.<sup>257</sup> This could also result in staff making inappropriate comments, leading survivors with disability to decline those services in future.<sup>258</sup> Appropriate education and training is an important component for the building of a trauma-informed service system.<sup>259</sup>

Sufficient funding is required for services to support staff training and education. Some services, in particular those in regional and remote areas, find funding does not always compensate for the costs involved for their staff to attend training and education opportunities.<sup>260</sup> Further, we have heard that new funding models have led to a reduction in funding allocated for training.<sup>261</sup>

Staff turnover and limited availability of courses can mean that workers do not receive timely training. Some services found that this lack of support affected staff retention as well as practitioners' ability to respond to and cope with their work.<sup>262</sup> One sexual assault service reported that the lack of training and education in trauma and child sexual abuse meant staff stopped wanting to work in the field.<sup>263</sup>

Training and education to ensure that practice was sensitive to the needs of particular population groups such as children and young people was identified as a gap.<sup>264</sup> In particular, the aged care sector required training and education in child sexual abuse and trauma to respond adequately to older survivors. There are a number of similarities between childhood and aged care settings, including dependence on others for daily needs, disempowering structures and compromised autonomy. As a result of this, entering an aged care facility may revive memories of childhood trauma for older survivors of sexual abuse.<sup>265</sup>

## Professional supervision

A key strategy for maintaining ethical practice and monitoring the quality, safety and wellbeing of staff is to provide external professional supervision, ensuring opportunities for counselling, debriefing, assistance, mentoring and clinical development. We were told about a range of different forms of supervision being used in different agencies and service sectors.<sup>266</sup> However, we heard that some organisations lacked a culture of mentoring and supervision, with the result that their staff received training only, with no follow-up or ongoing support mechanisms.<sup>267</sup>

We were told that appropriate external professional supervision is essential for staff retention, staff support and staff wellbeing.<sup>268</sup> Continued exposure to traumatic content without supervision and support can lead to burnout,<sup>269</sup> which can cause disruption to the support and treatment of clients and undermine the effectiveness of the workforce as a whole.<sup>270</sup> Research has found that interpreters, for example, were offered little in the way of debriefing or other support mechanisms despite the potential for vicarious trauma.<sup>271</sup> External professional supervision can reduce staff turnover<sup>272</sup> and mitigate the effect of vicarious trauma.<sup>273</sup>

Professional supervision is distinct from management in that it aims to foster the practitioner's clinical capacity rather than ensure their day-to-day activities are in line with the agency's priorities. Professional supervision should, wherever possible, be conducted externally in order to avoid conflicts of interest and to provide practitioners with the opportunity to debrief and reflect on their clinical experiences.

We consider that providing supervision is an ethical response by agencies seeking to support staff working in the field of sexual abuse and trauma.<sup>274</sup> Supervision is important for building and retaining a strong workforce. Supervision therefore underpins effective practice and is important for meeting the needs of victims and survivors of child sexual abuse. We consider the health and wellbeing of the workforce to be integral to the development of a trauma-informed workforce.

A culture of supervision and staff support should be considered an essential component of workforce health and safety. Training and education should be reinforced by regular supervision, holding services and professionals to account for the quality of their work.

### 4.4.2 Resourcing

Many agencies we heard from during our inquiry recognised the range of barriers victims and survivors had to overcome when trying to access their services. However, the agencies also told us of the challenges they encountered trying to address these barriers and provide accessible and innovative services. Many agencies told us that these issues existed due to resourcing constraints associated with funding, staff capacity and expertise.

Several submissions to our issues paper on advocacy and support and therapeutic treatment services discussed how limited resourcing inhibited effective service provision.<sup>275</sup> Funding limitations affected service delivery in a range of ways, including restricting the range of service options available to certain groups, such as secondary victims or survivors in the criminal justice system.<sup>276</sup>

Limited resourcing could also impair efforts to provide appropriate physical spaces or cover secondary costs associated with accessing support, such as transport or accommodation.<sup>277</sup> One service provider in our private roundtable on advocacy and support and therapeutic treatment commented that under-resourcing had become so widespread and had existed for so long that it had become 'normalised'.<sup>278</sup>

Many services attempted to use technology to provide accessible services to regional and remote communities. However, a lack of available equipment and suitable venues, and other costs associated with setting up an online environment, made it impossible for some providers to develop these services. The Canberra Rape Crisis Centre and Service Assisting Male Survivors of Sexual Assault described the effects of resource limitations:

From the point of view of smaller services like ours, resource limitations make it difficult to provide online information and support to survivors, supporters and anyone else who might benefit from further information about institutional child sexual abuse.<sup>279</sup>

In research we commissioned surveying practitioners working with survivors, respondents noted that short-term funding for services made it more difficult for individuals to access ongoing, affordable support.<sup>280</sup>

We were told that it was more expensive and time-consuming to deliver services in regional and remote areas compared to metropolitan centres.<sup>281</sup> The cost of providing a staff member for outreach work in regional or remote areas was compounded by the additional costs associated with travel time, fuel, vehicle hire or maintenance, and venue hire.<sup>282</sup> If the number of people requiring specialist services was small in particular communities, costs to the agency could rise,<sup>283</sup> potentially creating a barrier to providing these services and leading to further service gaps. For example, Anglicare WA told us of a number of issues it faced in providing support to remote communities, including a lack of funding compounded by higher costs associated with travel and accommodation, a lack of effective and timely law enforcement in remote areas, the status some perpetrators had within some communities and high staff turnover leading to a lack of knowledge regarding the local community.<sup>284</sup> We heard of time-limited appointments, with some regional services having to restrict after-hours responses at night and on weekends.<sup>285</sup>

### 4.4.3 Complexities within and between service and policy systems

Throughout our inquiry, we heard many examples of services delivering quality advocacy and support and therapeutic treatment that were meeting the needs of victims and survivors. However, there was also a strong message from both survivors and service providers about the range of systemic and structural barriers that made it difficult for survivors to get the services they needed. Victims and survivors could face a range of issues associated with their experiences of trauma and require multiple forms of support. However, we heard that services did not collaborate with one another, compounding the difficulties victims and survivors faced when navigating the complex policy and service environment.

#### Collaboration between service agencies

In our private roundtable on advocacy and support and therapeutic treatment, we were told by service agencies, academics and government agencies that the extent of collaboration between mainstream, community support and specialist services varied and at times was limited or non-existent.<sup>286</sup> This could be a reflection of the service system, the range of services victims and survivors used, the skill and knowledge of practitioners, restrictive funding models and the diversity of treatment and supports offered. Lack of collaboration could mean victims and survivors were caught between services, not receiving the benefit of the skill and expertise of different professionals or having to repeat their story. This could contribute to a narrow approach to a victim's or survivor's needs, which was ineffective at responding to trauma.

The lack of collaboration between services could mean victims' and survivors' needs were compartmentalised. For example, in commissioned research on pathways to support services, some survivors reported being encouraged to deal with their alcohol and other drug issues before they receive mental health services to address their trauma.<sup>287</sup> Such experiences could effectively exclude certain victims from certain services.<sup>288</sup> In a consensus statement to this Royal Commission the mental health commissions of Australia described the service system as 'highly siloed', noting:

it does not adequately respond to the complex diversity of need many survivors experience. Funding is provided for defined services, which are often driven by diagnosis, or presenting behaviours and with clearly demarcated outcomes. The system rarely works strategically and collaboratively to privilege an individual's holistic recovery across the life cycle.<sup>289</sup>

Collaboration between sectors could also be hampered by a lack of knowledge and communication, limited time and funding and concerns that collaboration could create more work.<sup>290</sup> It might also be hampered by differences in service models, ideological differences and the varied skill base of the professionals.<sup>291</sup> Research suggests that the alcohol and other drugs and sexual assault service sectors had not worked together effectively to support clients.<sup>292</sup>

We heard that the impact of trauma was often not acknowledged by alcohol and other drug services.<sup>293</sup> This could affect referral pathways and treatment outcomes, with victims' and survivors' therapeutic needs not being met.<sup>294</sup>

We were told that services for children and young people with particular needs – such as those with significant mental health needs, intellectual disability, young people in the youth detention system and young people receiving alcohol and other drug services – were often constrained by a lack of understanding and collaboration between these services and sexual assault services.<sup>295</sup> We were also told that current funding models created competition, with services focusing on demonstrating their differences to gain funding, rather than collaborating.<sup>296</sup> In a private session, 'Kaleb' told us that, despite being suicidal, he was expected to drive six hours to an acute mental health facility to receive treatment.<sup>297</sup> He said that 'it's because there's no coordination. You know, the right hand doesn't know what the left hand's doing. Everyone's competing because they're all trying to get funding'.<sup>298</sup>

We heard that collaboration between services often hinged on relationships between individual professionals rather than coordination between systems. One professional told us that even when victims and survivors were accessing support, it seemed to be a matter of luck as to whether they found a professional who had information and knowledge on support services that could assist.<sup>299</sup> This might be due to services' and professionals' own confusion and a lack of awareness of what was available and how to find the best services to meet their clients' needs.<sup>300</sup> Even when networks were strong and coordinated, we were told that referrals were often made informally, relying on goodwill, with no formal or legal basis.<sup>301</sup> This lack of formal arrangements can mean services do not have a consistent approach to referrals. Relationships Australia noted the lack of joined up services, agreements and memoranda of understanding between agencies with responsibility for issues such as housing, mental health, income support and general healthcare.<sup>302</sup>

This lack of specialist services and programs able to respond to survivors means that non-specialist service providers may have limited or no referral options when a client discloses a history of child sexual abuse.<sup>303</sup> In a submission to our issues paper on advocacy and support and therapeutic treatment services, Dr Michael Salter explained:

I have had health practitioners tell me that they do not believe it is safe or ethical to ask clients in their service about their abuse history, even when this may be relevant to treatment, because their service could not offer appropriate support, and they have nowhere to refer the client to.<sup>304</sup>

## Intersections between policy frameworks

As outlined in Chapter 3, the Australian health and social care system is a complex mix of federal, state and territory funding and responsibility, with services delivered through the public and private sectors.<sup>305</sup> The services used by victims and survivors of child sexual abuse are overseen by a range of government portfolios, including health, children and families, human and social services and justice. Each portfolio has a range of national frameworks and strategies that guide service delivery and workforce development in relation to specific health and social issues. Each framework has high-level priorities, with consistencies and differences across these frameworks in relation to recognising diverse needs, responding to child sexual abuse and implementing trauma-informed care. These inconsistencies have implications in the provision of consistent and integrated services to victims of child sexual abuse.

The issue of child sexual abuse can fall between national frameworks that guide service delivery, with little recognition of the relationship between specific health issues and child sexual abuse. We heard throughout our inquiry that experiences of trauma associated with child sexual abuse could increase an individual's risk of experiencing physical and mental health problems. We considered the extent to which trauma and child sexual abuse were evident across a range of national frameworks relating to health, mental health, disability, domestic violence and child protection.<sup>306</sup> While some frameworks made mention of trauma as an issue, only the Fourth National Mental Health Plan substantially engaged with the needs of victims and survivors of child sexual abuse.<sup>307</sup> Adult survivors of child sexual abuse largely fell between national policy agendas. Due to the lack of recognition of adult survivors across strategic policy frameworks, we heard of concerns that no government department held responsibility for their needs.<sup>308</sup>

Looking across national frameworks, it is clear there is no agreed trauma-informed approach. Nationally, mental health services have moved towards a recovery-oriented approach that incorporates trauma-informed principles. However, there are many national frameworks and strategies that impact on child and adult survivors of childhood sexual abuse that neither address trauma as a central area of need nor promote a trauma-informed approach. Ensuring all relevant frameworks and strategies promote trauma-informed care would bring about greater consistency in the identification of and response to victims and survivors of child sexual abuse as well as enhance the capacity of the workforce to respond effectively.



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# 5 Improving service systems for victims and survivors

## 5.1 Overview

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In this volume's two concluding chapters, we outline the reforms needed to meet the demand for services following the conclusion of the Royal Commission. These reforms will promote the responsiveness of the service system to the needs of victims and survivors of child sexual abuse, to support healing and recovery. These chapters also address the barriers faced by victims and survivors when seeking assistance, which limit the quality of services they can access.

In this chapter we discuss the conclusions we have drawn regarding service system reforms and make specific recommendations that focus on ensuring there are ongoing services for victims and survivors and on improving the responsiveness of mainstream services.

In Chapter 6 we recommend a mechanism for leadership at the national level aimed at improving help-seeking and best practice trauma-informed service responses.

## 5.2 The need for service system reform

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After hearing from thousands of victims and survivors in case studies, private sessions and written accounts, and through our commissioned research and our consultation processes with government and non-government organisations and agencies responsible for providing services, it is clear that improvements to service systems are needed. Such improvements should ensure that when seeking formal support, victims and survivors receive services that assist them on their journey of recovery and do not compound the trauma of institutional child sexual abuse.

As we established in Volume 2, *Nature and cause*, a great many individuals and the Australian community as a whole are already living with the trauma and bearing the costs of child sexual abuse that took place in institutional settings. Volume 3, *Impacts* shows that the lifetime effects on victims and families can be profound and broad-ranging, with cost implications related to ongoing healthcare, lost earnings and tax revenue, the heightened need for welfare and child protection and sometimes increased likelihood of criminal behaviour.

In Chapter 2 of this volume, we discussed how well-implemented services can assist a victim or survivor on their journey of recovery, improving physical and mental wellbeing as well as supporting social and economic participation. We heard many examples of services assisting victims and survivors to heal. Advocacy and support and therapeutic treatment – along with broader health, education, community services, job services, social housing, justice, aged care and disability services – play an important role in addressing interconnected impacts of child sexual abuse on victims and survivors.

During our inquiry we examined the ways in which service systems have not met the needs of victims and survivors. Based on the information presented to us and described in Chapter 4, we identified particular deficiencies in service systems that have prevented high-quality support responses to all victims and survivors. In many ways, service systems are set up at odds with the nature of victims' and survivors' needs. The current service system is fragmented, often responding to a particular need in isolation from others. Inadequacies in the service system are most apparent when a victim or survivor is experiencing multiple and complex impacts from child sexual abuse, and in cases where they may not fit the mainstream approach of a service.

Coupled with the dynamics and impacts of institutional child sexual abuse, this web of services can make seeking support unmanageable. Child sexual abuse is still a taboo subject for many of the public and for professionals, and remains misunderstood, under-reported, under-identified and under-treated. Quality standards for the delivery of advocacy and support and therapeutic treatment services are inconsistent. Services across Australian jurisdictions are piecemeal, demonstrating a lack of a coherent approach for supporting people who have been sexually abused in childhood. Limited skills and expertise in working with child sexual abuse and trauma – along with gaps in affordable services – compound service issues for victims and survivors. Where a victim or survivor lives, their cultural background or whether or not they have disability can also influence the availability and standard of service response.

It is our view that additional expenditure should be directed to improve service systems for victims and survivors to support them to heal and recover, interrupt cycles of cumulative trauma and, where required, enhance their ability to lead productive, fulfilling lives.

Improving human service responses will also benefit people affected by institutional child sexual abuse. Volume 3, *Impacts* notes that the best available evidence suggests that 14.0 to 26.8 per cent of girls and 5.2 to 12.0 per cent of boys experience non-penetrative abuse, such as non-penetrative contact abuse and exposure to pornography, before the age of 16.<sup>1</sup> An estimated 4.0 to 12.0 per cent of girls and 1.4 to 7.5 per cent of boys experience penetrative abuse.<sup>2</sup> The personal, social and economic costs of child sexual abuse and other forms of child abuse are large. We believe that improving human service responses has the potential to benefit a much larger group of people than those we heard about in the course of the work of the Royal Commission.

Without improvements to the service system, victims and survivors may continue to fall through service gaps or receive services that are ineffective. Worse still, a service response can risk replicating poor institutional responses and re-traumatise an individual. For services and professionals, failing to improve collaboration can mean knowledge and skills remain compartmentalised. A workforce lacking the requisite skills, knowledge and support mechanisms not only diminishes quality service provision, but can also undermine the wellbeing and professional sustainability of professionals working within a challenging field.



### 5.2.1 Our approach to improving service systems

Our recommendations in this volume are intended to guide funders and providers of advocacy and support and therapeutic treatment services to assist them in adequately meeting the needs of victims and survivors of institutional childhood sexual abuse, outside of redress. We are aware that important reforms to service systems in different jurisdictions are currently being implemented and many of these may benefit victims and survivors. For example, in Victoria, recommendations of the Royal Commission into Family Violence aimed to enhance access to sexual assault services.<sup>3</sup> At a national level, the Productivity Commission Inquiry into Introducing Competition and Informed User Choice into Human Services, as well as national mental health reforms and the National Disability Insurance Scheme, are all shaping how services are commissioned and delivered.<sup>4</sup> We want to ensure that improvements in the design of services through these reforms will appropriately respond to the needs of victims and survivors, taking into account all we have learned.

Although our inquiry has specifically examined child sexual abuse in institutional contexts, our work has made us aware of the broader issue of child sexual abuse in familial and other non-institutional settings. There are unique impacts and needs for victims and survivors sexually abused as children in institutional contexts – particularly those who were abused in residential facilities and religious settings – but many impacts are common to all victims and survivors of child sexual abuse. We recognise that the responses we have considered will in many circumstances be applicable to all survivors of child sexual abuse, no matter what the context of the abuse. Further, some of the necessary responses to survivors of institutional child sexual abuse can only be provided as part of a broader system relevant to all survivors of child sexual abuse, having regard to accessibility, efficiency and effectiveness.

We considered which approaches would be most efficient and effective, where broad systemic reform is required, and what benefits individual survivors and the wider Australian community would receive. We examined the current evidence for possible solutions to meet victims' and survivors' needs and tested them through our consultation processes. We are satisfied that the approach to system reform we have proposed would have the greatest positive impact for victims and survivors of institutional child sexual abuse.

The current service system has weaknesses and gaps that indicate a need for improvement and increased capacity. Equally important is the need for a well-coordinated, evidence-informed and responsive service system, implemented by a skilled workforce.

Having regard to what is likely to be the most efficient, effective and accessible means of meeting the needs of survivors and delivering our desired outcomes, this volume makes recommendations for services that are variously:

- targeted solely at responding to the needs of people who experienced child sexual abuse in institutional contexts
- targeted initially at responding to the needs of people who have experienced child sexual abuse in institutional settings, but are capable of expanding over time to meet the needs of people who have experienced child sexual abuse in any context, to allow a gradual commitment of resources
- targeted at responding to the needs of all people who have experienced child sexual abuse in whatever circumstances, to deliver optimal outcomes for the individual and provide significant benefits for the community.

These recommendations should be implemented to complement other reforms of the service system, including those being undertaken by the Australian Government and state and territory governments, in particular in relation to mental health.

## Aim of recommendations

Increasing the wellbeing of victims and survivors, their families and communities is central to this volume. To that end, the recommendations in this volume aim to achieve responsive service systems that:

- have the necessary components to respond adequately to victims' and survivors' support needs
- understand the ways child sexual abuse and institutional responses to it can affect an individual, their families and communities, and the way trauma can influence service needs
- provide a holistic response to victims and survivors as part of a cohesive systems approach
- support services and staff to sustainably work with victims and survivors safely, efficiently and effectively
- are underpinned by the principles of trauma-informed practice and an understanding of institutional child sexual abuse; and collaboration and availability, accessibility, acceptability and high quality.

The recommendations focus on meeting current service demands following the conclusion of the Royal Commission and on longer-term strategic reform to drive systemic improvements.

In this chapter, recommendations are aimed at achieving responsive service systems that include:

- a dedicated system of community-based support services for victims and survivors. This system should provide advocacy and support, including counselling, case management and brokerage assistance; and it should include Aboriginal and Torres Strait Islander healing approaches and disability-specific services
- a national service to assist victims and survivors to understand legal options and to navigate the legal system
- a national telephone helpline and website to be central, visible points through which victims, survivors, secondary victims, professionals and the wider community can get information and assistance to navigate the service system
- enhanced capacity of sexual assault services to provide specialised support for survivors
- trauma-informed mainstream services cognisant of the dynamics and impacts of institutional child sexual abuse.

In conducting our inquiry it became clear that national leadership was required to address barriers to help-seeking and translate best practice knowledge into service policy and practice in order to ensure high service quality. In Chapter 6 we recommend the establishment of a national centre dedicated to reducing the stigma surrounding experiences of child sexual abuse, maintaining national attention on the impacts of child sexual abuse, and building and translating evidence to inform the ongoing development of best practice advocacy and support and therapeutic treatment services.

### 5.3 A responsive service system

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The need for advocacy and support and therapeutic treatment services for victims and survivors of child sexual abuse in institutions will continue after the end of the Royal Commission. A network of services should be adequately resourced and supported to respond to these needs.

During the Royal Commission's five years of operation, demand for and uptake of support services from victims, survivors and their families who have engaged with the Royal Commission has been extensive.<sup>5</sup> Many survivors have long-term support needs. We know those needs can change throughout the course of a survivor's life, and that, for many survivors, needs that are not apparent now may arise later.<sup>6</sup> As public knowledge increases of the extent of child sexual abuse and as social stigma surrounding sexual abuse diminishes, demand may also arise from victims and survivors who have not engaged with the Royal Commission but have gradually become more prepared to seek assistance. In research surveying providers of Royal Commission support services, providers consistently indicated a need for ongoing support for victims and

survivors after the Royal Commission concluded.<sup>7</sup> One service provider responded, 'Support needs and provision of services are ongoing – not just a quick fix service ... It doesn't stop when the client undertakes their statement [to the Royal Commission]'.<sup>8</sup>

The importance of strengthening the service system to respond to the needs of victims and survivors at the conclusion of the Royal Commission has also been recognised more broadly. In June 2017 the Mental Health Commissions of Australia made a consensus statement to the Royal Commission identifying several 'essential elements' required to ensure that services are responsive to children and adults who have experienced child sexual abuse.<sup>9</sup> In addition to promoting the strength and resilience of survivors, building trauma capability of services and developing coordinated approaches, the mental health commissions identified the need to 'prepare for increased demand'.<sup>10</sup>

The process of the Royal Commission will have raised victims' expectations that appropriate services will be provided to meet their needs. Accordingly, governments can expect an increase in demand for services on an ongoing basis, whether through a redress scheme or otherwise ... There will need to be a mechanism for ensuring that the people who have engaged with the Royal Commission receive the services they need.<sup>11</sup>

It is clear that to provide accessible services to all victims and survivors of child sexual abuse in institutional contexts, we must ensure services are accessible and affordable for all. As discussed in Section 4.2.6, appropriate advocacy and support and therapeutic treatment is often unaffordable to survivors, meaning that many who want to engage in counselling or book further sessions may be forced to disengage from this kind of care. The limited choice of services and of accessible information for victims and survivors means they could face waiting lists of several months to receive therapeutic treatment that could be of varying quality.

In order to meet the demand for services following the conclusion of the Royal Commission and to ensure victims and survivors have access to the assistance they need in the immediate term, governments should resource comprehensive support services that respond to the full range of a survivor's physical, social, emotional and practical needs. We recommend the funding of dedicated community support services in each jurisdiction to provide advocacy and support and counselling for victims and survivors of child sexual abuse. An ongoing and integral part of this service system should be specific support for Aboriginal and Torres Strait Islander people and communities and people with disability.

Victims and survivors of institutional child sexual abuse also require support to navigate the range of legal processes they may engage with. We recommend the provision of a legal support service to provide victims and survivors with advice associated with obtaining records from institutions, and options for initiating police and civil litigation or redress processes as required.

As part of a comprehensive response to victims and survivors following the Royal Commission, information and support should be available from a telephone helpline and website.

Specialist sexual assault services should be adequately resourced to meet gaps in the provision of specialist therapeutic treatment for children and adults who experienced sexual abuse in childhood. Specialist sexual assault services should be available and accessible to victims and survivors with diverse backgrounds and needs.

Finally, mainstream services should be cognisant of the dynamics and impacts of institutional child sexual abuse and how to work with victims and survivors who present with trauma. The policy frameworks that guide these services should support them and build their capacity to translate trauma-informed approaches into various settings.

### 5.3.1 Community support services

As discussed in Chapter 3, the current service system in Australia is complex and often difficult for victims and survivors to navigate. Clarifying the pathways into and through the service system requires long-term reform, and the system may never be fully untangled. Victims and survivors need a place to go where they can easily access services grounded in a strong understanding of the impacts of child sexual abuse and effective institutional responses, with staff who know how to work alongside victims and survivors to address their support needs.

Many services have played an important role in supporting the victims and survivors we heard from throughout our inquiry, as well as victims and survivors who did not engage with the Royal Commission. The Australian Government Department of Social Services funded 37 organisations until 30 June 2018 to provide community-based support services to people who have been affected through their engagement with the Royal Commission. On completion of the Royal Commission it is likely demand will continue for this type of support.

We believe dedicated community-based services for victims and survivors of child sexual abuse should continue to be available. The model for these services should be an integrated, multidisciplinary, advocacy and support and counselling service. These services should be easily identifiable points of contact for victims, where they can receive immediate assistance and support to link directly to specialist sexual assault services or activities such as therapy, legal advice, peer support and housing assistance. Case management support and brokerage funding should be available as part of this service to those in need, whereas others will be assisted by receiving information and referral to an appropriate external service.

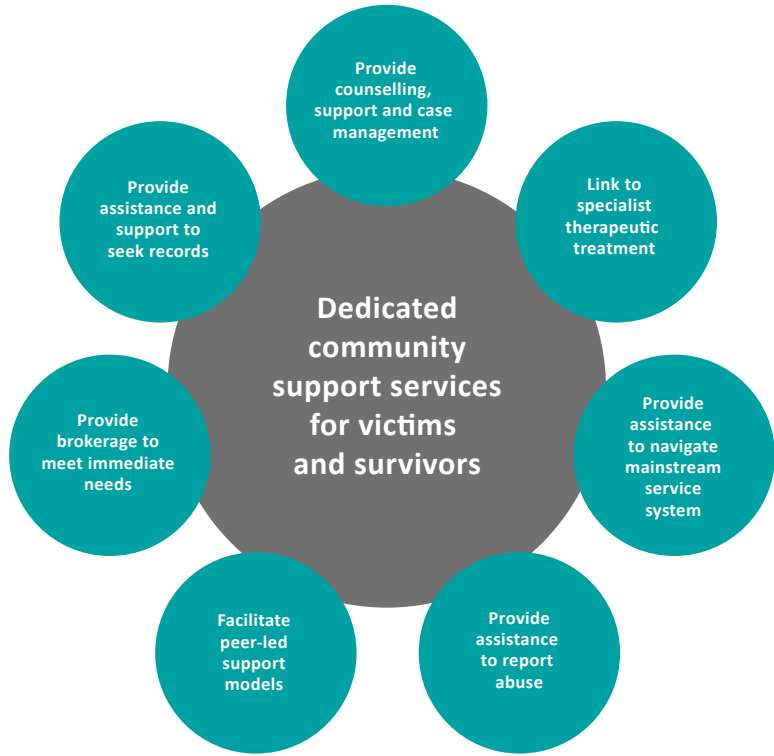
In Chapter 2, we identified the key principles and elements of service provision necessary to respond well to victims' and survivors' needs. This included a trauma-informed approach and an understanding of institutional child sexual abuse. These foundation principles informed subsequent principles of collaboration, availability, accessibility, acceptability and high quality. We also identified promising approaches to working with victims and survivors, including providing comprehensive case management and brokerage funding to address immediate practical needs, resolve crises, support access to services such as transport and purchase services outside the publicly funded system. We highlighted the importance of peer support

in helping victims and survivors to overcome feelings of guilt and betrayal, and reduce isolation through sharing their experiences with one another. The knowledge we gathered through victims and survivors, their families and those who worked with them should inform enhanced, ongoing service provision.

### Proposed victim and survivor community support services

Community-based services specific to victims and survivors of institutional child sexual abuse should be available to assist victims and survivors on their journey of recovery. These services should be a central point of contact for victims and survivors to receive ‘wraparound’ support. The services should work alongside individuals to meet their needs either by providing assistance directly, offering case management and brokerage, or by proactively linking them with an appropriate specialist service or activity.

These services should provide emotional support and counselling, including survivor-led peer-support activities. They should assist victims and survivors to navigate mainstream service systems, such as education, employment, legal and housing. Brokerage funding should be available to assist victims and survivors to meet practical needs. These services should help people to access their records, and assist them to report abuse where appropriate. This proposed model of community-based support is illustrated in Figure 9.1.



**Figure 9.1 – Proposed model of community support services for victims and survivors**

The target population for these dedicated community support services should be any victim or survivor of child sexual abuse in institutional contexts. The work of the Royal Commission has prompted increased demand for support from survivors and this demand is likely to continue after the Royal Commission concludes its work in 2017.

Community support services for victims and survivors should provide practical assistance to peer-led support groups, including by providing professional supervision where required. Many older survivors of child sexual abuse in residential institutions told us peer support was a particularly significant aspect of healing. We heard how the connections individuals formed during their time in institutions often took the place of family relationships and were a very important part of recovery. Many peer support services will be time-limited, having developed to meet the needs of these specific groups.

These community-based services should also target their activities towards survivors in contexts where access to support is limited. As discussed in Chapter 4, victims and survivors who are in detention environments and aged care settings can experience particular barriers in their journey of recovery. Therapeutic treatment services in these settings may not be available when needed, and help is required for survivors to identify and access specialists. Prevalence of violence, lack of privacy and frequent discipline from authority figures can place survivors in youth detention or adult prisons at particular risk of re-traumatisation. Many older survivors entering aged care settings may also be re-traumatised by the experience of re-institutionalisation, particularly if staff have inadequate knowledge or skills to respond to their needs. We are of the view that there is an acute need for improved access to therapeutic responses in these settings. Service responses should include a focus on improving safe access to advocacy and support and counselling for victims and survivors in detention environments and aged care settings.

#### **Recommendation 9.1**

The Australian Government and state and territory governments should fund dedicated community support services for victims and survivors in each jurisdiction, to provide an integrated model of advocacy and support and counselling to children and adults who experienced childhood sexual abuse in institutional contexts.

Funding and related agreements should require and enable these services to:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. use case management and brokerage to coordinate and meet service needs
- d. support and supervise peer-led support models.



## Aboriginal and Torres Strait Islander healing approaches

In Chapter 2 we outlined the importance of Aboriginal and Torres Strait Islander healing approaches, to support recovery for Aboriginal and Torres Strait Islander victims and survivors. These approaches emphasise connecting to culture and affirming a positive Aboriginal or Torres Strait Islander identity, including restoring family and community relationships. The need for Aboriginal and Torres Strait Islander healing approaches is supported by Australian and international research.<sup>12</sup> In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse)*, we heard evidence of how connection to culture supports resilience.<sup>13</sup> One expert described the importance of healing programs as part of recovery for victims and survivors.<sup>14</sup> Another expert told us that cultural practices such as ‘ceremony, being on Country, dance, [and] art’ can help to heal the neurological damage caused by trauma.<sup>15</sup> Stakeholders have also emphasised the need for healing approaches.<sup>16</sup> The results of the Healing Foundation literature review suggest a collective focus within these approaches can assist intergenerational healing.<sup>17</sup>

We have concluded that Aboriginal and Torres Strait Islander healing approaches are an important component of the service system. Such programs show promise in helping to address both the individual trauma of child sexual abuse in institutions and the collective and intergenerational trauma within many Aboriginal and Torres Strait Islander communities, which is a ripple effect of the abuse. Volume 3, *Impacts* discusses the ripple effects from contemporary experiences of child sexual abuse and those that manifest in the collective trauma that has resulted from child sexual abuse within the context of colonisation.

Funding for Aboriginal and Torres Strait Islander healing approaches and their formal evaluation should continue and be expanded. This should occur in conjunction with concerted efforts to improve the cultural safety and accessibility of mainstream services, and to support the development of clinical skills in Aboriginal Community Controlled Health Services. Evaluations of these approaches should be culturally appropriate.

It is likely that Aboriginal and Torres Strait Islander survivors of child sexual abuse within a family or community context would also benefit from access to Aboriginal and Torres Strait Islander healing approaches. We are of the view that it would be unnecessarily restrictive and impractical to limit the availability of culturally informed ways of healing to those abused in institutions.

Acknowledging the broader historical context of the sexual abuse of Aboriginal and Torres Strait Islander children in institutions, and recognising the collective, cultural impacts of this abuse, we adopt an inclusive approach to maximise community-wide benefits.

### **Recommendation 9.2**

The Australian Government and state and territory governments should fund Aboriginal and Torres Strait Islander healing approaches as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse. These approaches should be evaluated in accordance with culturally appropriate methodologies, to contribute to evidence of best practice.

## **Disability-specific services for victims and survivors**

Individuals with disability are exposed to greater risk of abuse than the general population, and their needs associated with managing the impacts of trauma are poorly met by the service system. Concerted efforts should be made to meet the concurrent need for expertise in both disability and child sexual abuse in order to support victims and survivors with disability. As with other victims and survivors, a holistic response involving advocacy and support and therapeutic treatment should be tailored to their individual needs.

As discussed in Volume 2, *Nature and cause*, children with disability are particularly vulnerable to maltreatment, including sexual abuse, across all settings.<sup>18</sup> There is evidence that children with disability are at increased risk of sexual abuse in institutional contexts.<sup>19</sup> Some individuals with disability are more dependent on services – for example, for personal and medical care or within residential institutions – compared to the general population. This dependence increases the risk of abuse and can also increase the need for advocacy.

As outlined in Chapter 2 of this volume, individual advocacy is particularly important in assisting people with disability to access essential services in often complex and fragmented service systems.<sup>20</sup> Recent inquiries into abuse in disability services have also highlighted this particular need.<sup>21</sup> In the Senate inquiry report into neglect, abuse and violence against people with disability in institutional and residential settings, the Senate Community Affairs References Committee acknowledged the vital role that formal and informal advocacy played in ensuring victims with disability were able to access the services they needed.<sup>22</sup> The committee noted that the advocacy sector urgently needed greater assistance from all levels of government to continue in this role. It recommended that all levels of government acknowledge the role of advocacy, using measures such as increased training for people with disability to help them self-report abuse and the introduction of funded advocacy programs to include training for informal advocates.<sup>23</sup> The committee also recommended increasing funding for advocates and self-advocacy programs to meet the greater demand for advocacy anticipated under the National Disability Insurance Scheme.<sup>24</sup>

The importance of advocacy for individuals with disability who experienced child sexual abuse was similarly highlighted in our inquiry. For example, Northcott, a disability support service in New South Wales and the ACT, told us that for people with cognitive impairment or complex communication needs, effective advocacy tailored to their individual needs could be important in assisting disclosure and the subsequent reporting of sexual abuse.<sup>25</sup> We agree with previous inquiries that advocacy is a vital part of a service response for victims and survivors.

Therapeutic responses are also an important part of the healing process. Survivors with disability rarely receive therapy specifically designed to meet their needs. Several studies have suggested that despite many services considering themselves to be accessible, people with disability find them inaccessible, particularly in relation to how services work with people with cognitive impairments or complex communication needs.<sup>26</sup> Studies with victims and survivors of sexual abuse with intellectual disabilities have found that few individuals received adequate therapy and some experienced cycles of successive referrals without receiving support.<sup>27</sup>

There can be an inverse relationship between expertise in working with people with disability and expertise in therapeutic responses.<sup>28</sup> Disability organisations told us that few support services working with people who have disability were trauma-informed, and that conversely many advocacy and support and therapeutic treatment services were not accessible to people with disability.<sup>29</sup> Persistent dismissive, discriminatory and stigmatising attitudes towards adults and children with disabilities can compound the impacts of child sexual abuse and impact on how services respond to disclosures of abuse and trauma.<sup>30</sup>

There is limited empirical, peer-reviewed literature about therapeutic interventions for people with disability who experienced sexual abuse in childhood.<sup>31</sup> This limits the capacity to provide definitive clinical guidance. However, a study we commissioned to look at current research on the service and support needs of specific populations suggested that it could be possible to adapt verbal and non-verbal therapies for people with intellectual disability.<sup>32</sup>

While evidence is still emerging on effective support approaches for victims and survivors with disability, it is an important space in which dedicated services with combined expertise in disability and child sexual abuse can assist with meeting service needs, as well as develop knowledge and best practice. Governments should ensure dedicated funding for community support services for victims and survivors specifically targeted at working with individuals with disability.

As in our proposed approach to Aboriginal and Torres Strait Islander healing programs, weighted resourcing for disability-specific support services should occur in conjunction with concerted efforts to improve the experience and skills of mainstream services to work with victims and survivors with disability, as well as develop clinical competence in disability-specific health services, so that victims and survivors with disability can access appropriate support.

Dedicated advocacy and support and therapeutic services for survivors with disability would benefit those who have experienced child sexual abuse within institutional contexts, as well as those who experienced child sexual abuse elsewhere. We know children with disability are exposed to greater risk of abuse than the general population, and the service system responds particularly poorly to the needs of victims and survivors with disability who have experienced child sexual abuse in any context. Victims and survivors with disability experience significant barriers to accessing mainstream services, and there are very few services specifically targeted at meeting their needs.

We made a broad commitment to recognise the diverse needs and experiences of survivors and ensure equitable service responsiveness for all victims. Consistent with this position, we are of the view that it would be counterproductive, unnecessarily restrictive and impractical to limit availability of these services solely to people with disability who experienced child sexual abuse in an institutional context. We believe that an inclusive approach would be the most efficient and effective way to address the significant barriers to accessing services that exist for people with disability. With this approach we aim to maximise the significant community-wide benefit of providing dedicated advocacy and support and therapeutic treatment services to survivors with disability across all jurisdictions.

#### **Recommendation 9.3**

The Australian Government and state and territory governments should fund support services for people with disability who have experienced sexual abuse in childhood as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse.

### **5.3.2 Support service to navigate legal processes**

In private sessions and consultations, we often heard of survivors' need for assistance in navigating legal processes. In particular, we heard that survivors needed support accessing redress and initiating police and civil litigation processes. In addition – as discussed in Volume 8, *Recordkeeping and information sharing* – survivors needed assistance to access records about them and, where appropriate, seek to amend or annotate their records. There should be adequate assistance for survivors to pursue any legal matters associated with their abuse history, independent from the institutions responsible or implicated in those matters.

As with other service systems we considered in our inquiry, the complexity of the legal system, negative previous experiences with this system and the impacts of trauma can leave victims and survivors feeling disempowered and cause them additional and unnecessary distress. Legal elements within other service systems can also be difficult for victims and survivors to manage. A range of services working with child and adult victims and survivors identified the need for assistance in navigating these processes.<sup>33</sup> For example, in a submission to our *Advocacy and support and therapeutic treatment services* issues paper, the national body representing eight Relationships Australia organisations across the country discussed its workers' experiences with Aboriginal and Torres Strait Islander survivors, reflecting on the need for 'support in accessing redress as they have often lost faith in the legal system due to failed prosecutions in the past'.<sup>34</sup>

Assistance for victims and survivors with legal processes is currently delivered through various services, including:

- integrated multidisciplinary services
- community legal centres
- community-based organisations
- witness assistance services.

To assist victims and survivors on their journey of recovery, a number of services promoted a trauma-informed approach for the provision of assistance with legal processes.<sup>35</sup> Such an approach is appropriate as it prioritises safety, trust, collaboration, choice and empowerment within processes that necessarily involve revisiting traumatic experiences – for example, providing statements about the abuse. The service knowmore was funded to provide free legal advice to individuals who tell their story to the Royal Commission. We were told by knowmore that trauma-informed practices in legal advice can be linked to positive therapeutic outcomes:

effective client participation in exercising or progressing legal rights can contribute positively to the achievement of ... broader therapeutic outcomes ... such as reduction in symptoms of ill-health or the bringing about of measurable change that improves wellbeing and quality of life.<sup>36</sup>

The service should focus on assisting survivors to access, amend and annotate records, understand their options for initiating police reports and civil litigation, make referrals for legal representation and provide general assistance in navigating the legal service system. The service should be guided by the service system principles for healing and recovery outlined in Chapter 2 of this volume.

The Australian Government should consider expanding legal supports to all victims and survivors of child sexual abuse over time.

#### **Recommendation 9.4**

The Australian Government should establish and fund a legal advice and referral service for victims and survivors of institutional child sexual abuse. The service should provide advice about accessing, amending and annotating records from institutions, and options for initiating police, civil litigation or redress processes as required. Support should include advice, referrals to other legal services for representation and general assistance for people to navigate the legal service system.

Funding and related agreements should require and enable these services to be:

- a. trauma-informed and have an understanding of institutional child sexual abuse
- b. collaborative, available, accessible, acceptable and high quality.

### **5.3.3 National telephone helpline and website**

As part of a comprehensive response to victims and survivors, information and support should be available from a telephone helpline and website. Lack of accessible information can leave victims and survivors and their families feeling confused, frustrated and unable to access the services they need. We believe there should be a visible, centralised helpline and website so that victims, survivors, the general public and practitioners are able to access the information about appropriate services for children and adults who have experienced child sexual abuse.

#### **The need for responsive telephone helplines and websites**

Victims and survivors who want help with issues related to their childhood sexual abuse need a safe, reliable and easily accessible source of information.

As we discuss in Section 4.2, survivors told us that they faced many barriers to getting assistance from services. These included difficulties finding relevant information, not knowing what services existed, and problems finding a service that was available when it was needed and in an accessible format. Research we commissioned, survivors' stories and written submissions from support services all confirmed the problem of finding timely, appropriate and skilled help. Not knowing about available services ultimately prevented many survivors from getting support.

In our consultation processes, governments, services and practitioners discussed the need for helplines and websites. Some submissions promoted the need for a helpline and website to provide independent and trusted information about, and referrals to, services.<sup>37</sup> For example, Mr Mark Griffiths, a practitioner, argued for providing guidance to point survivors towards reliable resources:

Rather than just leaving survivors to search through the available information online, government health and legal agencies could provide guidance towards those resources that provide correct, reliable information that is not going to exploit or misinform survivors or promote an irresponsible fringe approach.<sup>38</sup>

Some submissions discussed the need for 24-hour helplines for more immediate support and counselling.<sup>39</sup> For example, the South Australian Government highlighted the need for accessible telephone and online support to provide assistance in crisis circumstances and fill gaps when other services were unavailable:

People will access therapeutic services often when their discomfort levels are very high and they are in a lot of emotional pain. Their pain management strategies may no longer be working and [they] may be desperate for relief. This is the window of opportunity for the counsellor, therapist or helper to engage with the person. Waiting lists do not work for traumatised people. Access to 24-hour phone/online crisis services that are trauma-informed, understand the neurobiology of sexual assault trauma, cater to children, youth and adults, are staffed by professionals who can support people until they are able to ... access ongoing therapy is essential ...<sup>40</sup>

## Existing helplines and websites

Multiple services that provide information, referrals and counselling through national telephone and online services already exist.<sup>41</sup> We are interested in utilising existing infrastructure to provide relevant information and support to victims and survivors.

Many telephone and online services have been developed to respond to specific issues, such as anxiety and depression or sexual and domestic violence, including *beyondblue* and 1800 RESPECT. Others services provide an opportunity for people to seek assistance for a range of issues – for example, Kids Helpline, Lifeline and MensLine. Two existing national helplines – the Blue Knot Helpline and the Child Wise National Child Abuse Helpline – provide professional telephone support, information, resources, tools and workshops related to child abuse. However, both of these helplines have limited operating hours. During the life of the Royal Commission, four helplines were funded to provide information, referral and counselling to victims and survivors of child sexual abuse through national telephone and online services.<sup>42</sup>

State and territory governments also operate a range of helplines. For example, New South Wales has a 24-hour state-wide Child Abuse, Sexual Assault Clinical Advice Line providing psychosocial, medical and forensic responses to victims, and specialist advice to assist medical practitioners in providing examinations.<sup>43</sup>



The National Mental Health Commission's 2015 Review of Mental Health Programmes and Services noted the complexity of existing online, mobile phone and telephone mental health services in Australia, and described how poor integration of these services was creating difficulties for consumers in navigating and accessing what they needed.<sup>44</sup> In response to this review, the Australian Government committed to introducing a new 'digital mental health gateway'.<sup>45</sup> This gateway will bring together services to streamline access for consumers through a centralised telephone and web portal, and will operate as a first point of contact for information, resources, advice and treatment options.<sup>46</sup>

We do not seek to duplicate the support that is already offered through these services. However, we are of the view that there should be a visible, central point of contact for victims and survivors seeking assistance. This point of contact should be responsive to the impacts of child sexual abuse and have the relevant expertise to effectively assist victims and survivors with their journey of recovery. Establishing a responsive telephone helpline and website equipped to deliver information and support beyond the Royal Commission would ensure that expertise in trauma and child sexual abuse was available to assist victims and survivors to navigate a complex, fragmented service system. A telephone and online approach would also improve access to information and support and increase options for seeking assistance. A website could be an effective tool for educating children, young people, adults, families, carers, workers and the wider community about the impacts of child sexual abuse in institutions.

Acknowledging the various entry points into the service system for victims and survivors, the funding of such a telephone helpline and website should occur in conjunction with efforts to ensure all similar telephone helplines and online supports have relevant information as well as informed staff to deal with the impacts of child sexual abuse and institutional responses.

A national telephone helpline and website could provide an easy method of access into the service system for those who have been affected by child sexual abuse. Restricting this service to those who have experienced child sexual abuse in an institutional context is likely to be impractical and inefficient. Once a victim decides to seek assistance for the trauma associated with child sexual abuse, the context the abuse occurred in should not be a barrier to accessing the support system. This service should therefore be broadly accessible and relevant to all victims and survivors of child sexual abuse.

While the Australian Government has announced funding for a website and telephone helpline to provide information about the Commonwealth Redress Scheme, we have identified a need from a larger group of people for a broader range of information and support. A website and telephone line should be available to victims and survivors, the general public and practitioners to provide information about supporting children and adults who have experienced sexual abuse in childhood and available services. Such a service could be part of an existing website and telephone helpline attached to a relevant agency with appropriate experience. It is important that information and support is tailored to diverse needs, including those of children and young people, Aboriginal and Torres Strait Islander people and communities, people with disability and people from culturally and linguistically diverse backgrounds.

### **Recommendation 9.5**

The Australian Government should fund a national website and helpline as a gateway to accessible advice and information on childhood sexual abuse. This should provide information for victims and survivors, particularly victims and survivors of institutional child sexual abuse, the general public and practitioners about supporting children and adults who have experienced sexual abuse in childhood and available services. The gateway may be operated by an existing service with appropriate experience and should:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. provide telephone and online information and initial support for victims and survivors, including independent legal information and information about reporting to police
- d. provide assisted referrals to advocacy and support and therapeutic treatment services.

### **5.3.4 Specialist sexual assault services**

Specialist sexual assault services are an important part of the service system for victims and survivors. They can provide ‘first response’ to a victim and holistic support to a survivor through specialist therapeutic treatment, advocacy in navigating the system and referrals for other needs. Of the survivors in private sessions who said they accessed any formal service, 11.1 per cent said they accessed a sexual assault service. Four in five survivors who said they accessed a sexual assault service rated their experience. Of these survivors, the majority (78.7 per cent) stated that they were mostly satisfied or partially satisfied with the service.<sup>47</sup> In research we commissioned, involving interviews with survivors about pathways to support services, many participants who had accessed sexual assault services nominated them as helpful sources of information in the years following sexual abuse.<sup>48</sup> One study noted that the delivery of standardised and high-quality services to a victim assisted in positive health outcomes.<sup>49</sup>

However, it is a significant and ongoing challenge for specialist sexual assault services to meet the needs of child and adult victims and survivors of child sexual abuse in Australia. These services have grown in an ad hoc way in response to local need and available funding, resulting in a fragmented system.<sup>50</sup> We have heard in private sessions and our consultation processes about long waiting lists, a lack of resources limiting the range of programs and gaps in services – including gaps in services for men, people with disability, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

We are of the view that measures should be taken to build the capacity of sexual assault services in order to improve access for victims and survivors.

## Current state of sexual assault services in Australia

As outlined in Chapter 3, the specialist sexual assault service sector encompasses both government and non-government services providing a range of responses to child sexual abuse across jurisdictions. Funding for sexual assault services comes predominantly from state and territory governments. In Chapter 4, we explain how specialist services are currently stretched to full capacity and struggle to meet demand.<sup>51</sup> Some state and territory governments have recognised in recent budget announcements the need for increased investment in sexual assault services, to improve the quality and accessibility of services for all victims and survivors.<sup>52</sup>

A range of barriers prevent victims and survivors from accessing services, including long waiting lists, a lack of services – particularly in regional and remote areas – and a real or perceived lack of staff with skills and expertise to meet victims' and survivors' needs. For Aboriginal and Torres Strait Islander people, it is recognised that many of these services are not culturally safe; however, few specialist sexual assault services specific to Aboriginal and Torres Strait Islander people are available. Services for adult survivors, particularly males and people with disability, are piecemeal and frequently unavailable. In submissions to us, sexual assault services noted that limited resourcing inhibited their ability to provide the range of programs needed for positive outcomes, such as outreach or group work.

We heard from survivors that sexual assault services provided quality responses. However, evaluations on sexual assault services and their programs are limited.<sup>53</sup> Governments have recognised the need for evaluating sexual assault services.<sup>54</sup> Some sexual assault services told us in their submissions that they wanted to evaluate their processes, but did not have the resources or capacity to do so.<sup>55</sup> We are of the view that for quality assurance and accountability to victims, evaluative work should be part of any ongoing funding and design of sexual assault services.

## Enhancing sexual assault services

Improved access to specialist sexual assault services for all victims and survivors of child sexual abuse is needed across and within jurisdictions. Government investment would be required to build the capacity of the sexual assault services sector to better meet the needs of victims and survivors. A strategic approach by government to this investment is essential to ensure initiatives are tailored to meet existing services gaps.

Funders and providers should apply approaches that ensure sexual assault services are trauma-informed and have an understanding of child sexual abuse and institutional responses to it, as well as being collaborative, available, accessible, acceptable and good quality.

## Improving availability

To be able to adhere to the principles for healing and recovery outlined in Chapter 2, and address current unmet needs, funding to specialist sexual assault services should be increased so services are adequately resourced. Governments should invest to ensure that the specialist sexual assault service sector has the capacity to undertake the work required. The Third Action Plan 2016–2019 of the National Plan to Reduce Violence against Women and their Children 2010–2022 identifies the need for front-line services to be better supported to refer victims and survivors of sexual assault to specialist sexual assault services.<sup>56</sup> A well-resourced and supported sexual assault service sector is necessary to meet this demand as well as to provide services to male victims and survivors.

An enhanced sexual assault service sector is needed. The Blue Knot Foundation noted in a submission to us that the demand for specialist services could not be overstated and these services would require expansion to meet needs.<sup>57</sup> Further, the Senate inquiry into violence, abuse and neglect against people with disability recommended all levels of government provide increased funding for support and counselling services – such as those provided by specialist sexual assault services – so they could meet the needs of people with disability.<sup>58</sup> At our private roundtable on advocacy and support and therapeutic treatment it was noted that funding to the specialist system would increase the availability of trauma counselling.<sup>59</sup> Properly resourcing these services would also help them to build and further develop their existing body of knowledge.<sup>60</sup>

Submissions from sexual assault services to our *Advocacy and support and therapeutic treatment services* issues paper advocated enhanced funding to enable sexual assault services to be locally available, physically accessible, timely in their initial response and flexible in service delivery, by providing outreach services and using telemedicine and online counselling.<sup>61</sup>

Sexual assault services need to have a tailored approach to meet the diverse needs of victims and survivors. This is reinforced in *Time for action: The National Council's plan for Australia to reduce violence against women and their children, 2009–2021*, which noted that counselling services needed to not only provide ready access, but also have the resources and skills to respond to diverse needs.<sup>62</sup> One of the ways services can connect with diverse communities is to undertake community development, prevention programs and outreach work. Such strategies are also important because they offer practitioners a broader scope of the work and therefore choice of work – which can help to reduce the chances of them experiencing vicarious trauma.

In Section 4.3 we identified that regional and remote communities have limited access and choice of services. Victims in these areas are disadvantaged by the inequitable distribution of professionals and the lack of specialist services. Investment in sexual assault services should therefore consider regional and remote communities. Sexual assault services, in their submissions to our issues paper on advocacy and support and therapeutic treatment services, supported an increase in the number of sexual assault services to enable regional and remote

communities to have access to better care, including greater choice of practitioners, accessible centres that allowed for privacy and confidentiality, adequate and cost-effective transport, and access to free phone, online or video counselling.<sup>63</sup> We acknowledge the ongoing challenges of meeting such a goal and recognise that strategies to overcome these challenges would need to include innovative approaches.

Outreach services are essential to improving accessibility, as some victims and survivors may not feel comfortable entering the sexual assault service environment and may also need access to transport. Some victims are more effectively empowered when services are delivered in places they have identified as safe.<sup>64</sup> Teleconferencing or online advice is another way to provide outreach. However, this can be limited in regional and remote areas by a lack of, or by the prohibitive cost of, adequate and reliable internet coverage.<sup>65</sup> We also heard from sexual assault services that this form of service should not come at the expense of more mobile face-to-face services.<sup>66</sup>

## Improving collaboration and acceptability

Investment in the sexual assault service sector should promote collaborative work across sectors to meet service gaps and build and share knowledge and expertise across the whole service system. The sector should also ensure that those population groups who are known to be at greater risk of abuse in childhood form a proportionate part of their client group. This is in line with a human rights approach and reflects the diversity of the population and of victims.

With enhanced capacity the specialist sexual assault service sector would be able to undertake a more comprehensive, collaborative approach, through which expertise can be shared between specialist and mainstream services. A collaborative approach to service delivery, where there is consistency and support at all levels for victims and survivors, is supported by experts in the field and the available literature.<sup>67</sup> Such an approach reaches out to population groups, enhances service provision, provides a service best suited to victims' needs and builds the skill base of other workers. Collaboration with other agencies can address some of the barriers to service provision.<sup>68</sup> For example, a victim's needs may best be met through an Aboriginal and Torres Strait Islander health service that is supported in its work by a specialist sexual assault service.

In addition to new funding arrangements to support collaborative work, the existing structure of Primary Health Networks should be utilised. Primary Health Networks should, within their commissioning role, take the lead in facilitating formal working partnerships between the sexual assault service sector and key services, such as Aboriginal Community Controlled Health Services, disability-specific services, culturally and linguistically diverse services, mental health and drug and alcohol services, aged care services, youth justice and correctional services, and services for children and young people. Through this collaboration, skills, knowledge and expertise could be shared and victims could receive a more seamless service aimed at meeting all their needs.

## Improving quality

To ensure quality assurance and accountability, any investment in sexual assault services should support the ongoing evaluation of programs and services, with funding contingent on implementing such initiatives. By continually monitoring for quality, both existing and future services would be able to ensure they are meeting the varied needs of victims and survivors.<sup>69</sup> Services should assume accountability for overcoming barriers to meeting these needs, with successful treatment of victims and survivors being a core focus.

Funding should be provided for effective external professional supervision of staff, to prevent burnout and promote staff wellbeing. Ongoing supervision would identify when professional support was needed and what skills should be developed, thereby mitigating the impact of vicarious trauma. A research study conducted in Western Australia on health professionals' perceptions of management practices in sexual assault services provided a number of recommendations to help maintain staff health, including self-care strategies, effective staff supervision, access to debriefing, staff and peer support and a workplace culture that acknowledges trauma.<sup>70</sup>

A comprehensive professional development program is essential to service quality. Some jurisdictions have already adopted education programs for staff in sexual assault services to ensure levels of skill, qualification and experience are maintained. The Canberra Rape Crisis Centre and Service Assisting Male Survivors of Sexual Assault highlighted in its submission to us that survivors benefited from therapeutic treatment delivered from a trauma-informed perspective and supported by a strong professional structure, including a practitioner's development framework based on current research, regular external professional supervision and access to support for vicarious trauma.<sup>71</sup>

The barriers to effective sexual assault service responses we examined were systemic and not unique to victims of child sexual abuse in institutional contexts. For example, sexual assault service shortages for men, people with disability, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds were not necessarily specific to victims and survivors of child sexual abuse in institutions.

The enhanced funding we recommend would initially address the needs of victims and survivors of child sexual abuse in institutional contexts. Demand for such support has been increasing and it is reasonable to expect that this will continue as a result of the Royal Commission's work. Existing specialist sexual assault services in each jurisdiction will likely be called upon to respond to this ongoing demand. Although our inquiry has specifically examined child sexual abuse in institutional contexts, we recognise that specialist sexual assault services should be enhanced as part of a broader and more inclusive approach. We are of the view that building the capacity of the current network of sexual assault services should help agencies respond more appropriately to victims and survivors of child sexual abuse in institutional and non-institutional contexts over time.

### **Recommendation 9.6**

The Australian Government and state and territory governments should address existing specialist sexual assault service gaps by increasing funding for adult and child sexual assault services in each jurisdiction, to provide advocacy and support and specialist therapeutic treatment for victims and survivors, particularly victims and survivors of institutional child sexual abuse. Funding agreements should require and enable services to:

- a. be trauma-informed and have an understanding of institutional child sexual abuse
- b. be collaborative, available, accessible, acceptable and high quality
- c. use collaborative community development approaches
- d. provide staff with supervision and professional development.

### **Recommendation 9.7**

Primary Health Networks, within their role to commission joined up local primary care services, should support sexual assault services to work collaboratively with key services such as disability-specific services, Aboriginal and Torres Strait Islander services, culturally and linguistically diverse services, youth justice, aged care and child and youth services to better meet the needs of victims and survivors.

## **5.3.5 Responsive mainstream services**

Ensuring that the various entry points into service systems are safe for victims and survivors and providing or connecting them with the assistance they need is essential to responsive service systems. Many victims and survivors engage with mainstream services to seek assistance with the broad-ranging impacts of trauma relating to institutional child sexual abuse. When victims and survivors engage with services, a holistic response can be an important part of their journey of recovery. Mainstream services should have an understanding of the impacts of institutional child sexual abuse and how to work with trauma as it relates to their own service context.

A systemic approach is required to influence the practices of mainstream services. Based on the information we analysed from our case studies, private sessions, research and consultation processes with victims and survivors, service providers, academics and governments, we are of the view that consideration of the needs of victims and survivors with trauma when developing policies guiding service delivery – combined with support to translate trauma-informed approaches into various service settings – will help ensure victims' and survivors' needs are met by mainstream services.



## A system-wide approach

As discussed in Chapter 2, it is our view that advocacy and support and therapeutic treatment services that incorporate an understanding of child sexual abuse and apply trauma-informed approaches are beneficial for victims and survivors of child sexual abuse.

Trauma-informed approaches are emerging in Australia and are increasingly being recognised in various sectors and by individual services. While individual trauma-informed services can benefit the victims and survivors who access them, a trauma-informed approach is a system-level intervention, and therefore requires system-level infrastructure. As NSW Mental Health Commissioner John Feneley told us in the *Nature, cause and impact of child sexual abuse* public hearing, improving mainstream service systems' responsiveness to trauma is necessary in recognition of the multifaceted pathways by which people access services, as well as the complexities of child sexual abuse and the dynamics surrounding disclosure:

the reason why we need trauma-informed care to be the fabric of our system is because by far and away the bulk of the people that we are concerned about aren't known – they haven't yet disclosed. And so our systems have to adopt trauma-informed care approaches as second nature, right from our primary care systems through to our hospitals, to make sure that we start asking people, 'What happened to you?', not 'What's wrong with you?', and to actually build that in to everything we do.<sup>72</sup>

We commissioned research to examine what the available literature said about the understanding and application of trauma-informed care in Australia and internationally.<sup>73</sup> This commissioned research suggested that while the adoption of trauma-informed approaches was at an early stage in Australia, there was significant service, policy and research interest in systemic change and models of care. Trauma-informed care is being, or has been, implemented in Australia in service settings such as mental health, youth detention and correctional services, youth residential care and schools.<sup>74</sup> This has occurred in response to the fragmented and siloed systems of care individuals have encountered when attempting to access and navigate services in areas like mental health, substance use, income support and housing.<sup>75</sup>

The research also highlighted the importance of a nationally consistent approach to embedding trauma-informed care in frameworks and strategies, and in practice and policy development. It found administrative policies and initiatives were required at the systems level to: address government policy and responsibility for systems change; to support funding models for the development of a trauma-informed service system; and to foster the recruitment, hiring and retention of staff members with an understanding of trauma.<sup>76</sup> These initiatives are based on the premise that improvements in services will not occur unless the system they sit within adjusts to accommodate those improvements. This would involve making changes to the underlying structures and supporting mechanisms that operate within the system – including policies, resources, relationships, routines, power structures and values.<sup>77</sup>

Multiple submissions to our *Advocacy and support and therapeutic treatment services* issues paper noted the importance of implementing trauma-informed care across the wide range of human services with which victims and survivors of child sexual abuse interact.<sup>78</sup> These included mental health, alcohol and other drugs, child protection, homelessness, family services, aged care and disability, among others. In its submission, Family Planning NSW emphasised the importance of system-level implementation:

Meaningful support to victims and survivors of past sexual abuse, as well as those suffering present or future abuse, will require systemic implementation of trauma-informed services, including both training of service providers, quality assurance in relation to their work and the accessibility of services to people in all locations, including people living in rural and remote areas.<sup>79</sup>

Participants at our private roundtable on advocacy and support and therapeutic treatment also supported the idea of an overarching national approach to implementing trauma-informed care that would be driven through government policy frameworks. Participants noted that such an approach would encourage a move away from the current raft of inconsistent jurisdictional models.<sup>80</sup> It would also encourage an examination of how the principles of trauma-informed care could be implemented consistently across different government departments and service areas, such as justice, legal services, corrections and therapeutic services.<sup>81</sup>

Research published by the Royal Commission also identified promising international evidence of the value of implementing a trauma-informed approach across service systems.<sup>82</sup> For example, in the United States, participants in an evaluation of a pilot project of the trauma-informed care initiative ‘Using trauma theory to design service systems’ noted positive, agency-wide effects.<sup>83</sup> Administrators described increased collaboration between clinicians and consumers under the pilot project. Clinicians highlighted the value of the greater emphasis on physical and personal safety and enhanced trauma assessment that the trauma-informed approach provided. Importantly, service users described feeling that they had a more significant voice in the services they received and an enhanced sense of safety and collaboration with agency staff.<sup>84</sup>

## Recognising victims and survivors in national policy frameworks

National policy frameworks and strategies set priorities for service systems and drive reform. For example, the Australian Government Department of Health’s *Roadmap for national mental health reform 2012-2022* outlines the reform directions governments will take over the decade. The roadmap commits governments to making changes to the way mental health services are provided, with the aim of improving the lives of people with mental illness, as well as their families, carers and communities.<sup>85</sup>

As discussed in Section 4.4, there are numerous national policy frameworks that directly affect services relevant to children and adults who experienced childhood sexual abuse. These frameworks span health and social service areas, such as alcohol and other drugs, disability and mental health. Many of these existing frameworks do not address the needs of victims and survivors of child sexual abuse or provide direction on how an understanding of trauma may usefully inform approaches to service provision. For example, one study of mental health policy development in Australia noted that while existing mental health policies recognised that child sexual abuse was associated with detrimental impacts on mental health, many did not consider the implications of these experiences of trauma for mental health service delivery.<sup>86</sup>

Throughout our inquiry, we heard that despite being over-represented in several service settings, survivors were not recognised in national policy frameworks and therefore were not prioritised. As a result, their needs have long been left unmet.

It is our view that recognising victims and survivors, including secondary victims, and the impacts of child sexual abuse and trauma in national policy frameworks would provide the necessary foundations for better service delivery to victims and survivors, as well as helping services identify the elements of a trauma-informed approach and understand how it could be implemented in particular human service contexts. This would mean victims and survivors of child sexual abuse could be provided with safe, effective, person-centred and empowering services that take into account the impacts of child sexual abuse and do not put them at risk of being re-traumatised. In the *Nature, cause and impact of child sexual abuse* public hearing, NSW Mental Health Commissioner John Feneley described the importance of policy frameworks that enable health services to be responsive to the needs of victims and survivors:

I have to say, I have a great faith in primary care and general practice, but you need to find the time and to help them prioritise the need for their practices to become trauma-informed. Again, there are some great models out there where entire practices rebuild their services around recovery focused trauma-informed care principles, where everybody from the receptionist through to the doctor has this firmly in mind. But that won't happen overnight. So we need to have policy settings that encourage it and reward it to make sure that it happens.<sup>87</sup>

While we consider that all policy frameworks relating to human services should be updated to integrate a trauma-informed approach and recognition of the needs of victims and survivors of child sexual abuse, we have identified the following frameworks as particularly relevant to the needs of victims and survivors of institutional child sexual abuse. When reviewing these frameworks and associated action plans, the Australian Government agencies responsible should recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches to ensure that national services can better respond to victims and survivors:

- Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009–2020<sup>88</sup>
- The Roadmap for National Mental Health Reform 2012–2022<sup>89</sup> and the Fifth National Mental Health Plan<sup>90</sup>
- National Disability Strategy 2010–2020<sup>91</sup>
- National Suicide Prevention Strategy<sup>92</sup>
- National Drug Strategy 2016–2025<sup>93</sup>
- National Primary Health Care Strategic Framework<sup>94</sup>
- National Strategic Framework for Rural and Remote Health<sup>95</sup>
- National Aboriginal and Torres Strait Islander Health Plan 2013–2023<sup>96</sup>
- Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health<sup>97</sup>
- National Framework for Universal Child and Family Health Services<sup>98</sup>
- National Framework for Child and Family Health Services – secondary and tertiary services<sup>99</sup>
- National Male Health Policy<sup>100</sup>
- National Women’s Health Policy 2010<sup>101</sup>
- National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015<sup>102</sup>

Recognition of how trauma-informed approaches in policy frameworks could address the needs of victims and survivors of child sexual abuse in institutional contexts would have broad-reaching impacts. Filtering service responses through a trauma-informed lens for victims and survivors of child sexual abuse in institutional contexts would also improve responses for child sexual abuse victims and survivors in general.

We are of the view that it would be both impractical and unnecessarily restrictive to limit these proposed changes to policy frameworks to responses to victims and survivors of institutional child sexual abuse. It is our view that a broader focus on child sexual abuse generally is the most efficient and effective means of imparting lasting change in Australia’s public policy landscape.

### **Recommendation 9.8**

The Australian Government and state and territory government agencies responsible for the delivery of human services should ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches.

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## 6 National leadership to reduce stigma, promote help-seeking and support good practice

### 6.1 Overview

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Clearly, the work of this Commission over the past four or five years is one really important step ... but we need to make sure that it is maintained beyond the life of this Commission.<sup>1</sup>

The impacts of child sexual abuse are compounded by secrecy and silence.<sup>2</sup> During five years of inquiry the Royal Commission has drawn unprecedented attention to the experiences and needs of victims and survivors of institutional child sexual abuse, attracting extensive national and international media coverage. In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts (Nature, cause and impact of child sexual abuse)*, we heard evidence from experts, as well as survivors and their families, that public discussion of child sexual abuse at the Royal Commission has led to growing awareness of the issue in the community.<sup>3</sup> Ms Aileen Ashford, CEO of the Child and Family Organisation, explained that the work of the Royal Commission ‘has brought institutional sexual abuse into the public domain, shattered the secrecy, given victims and families hope that change will occur’.<sup>4</sup> In short, the prominence of the Royal Commission has prompted change.

Without high-profile national leadership, progress may stall. While a number of organisations exist that advocate for victims and survivors and support awareness raising in related areas of trauma and child maltreatment, there is no national focus specifically on child sexual abuse. When the Royal Commission concludes, there will be a gap in this area. We know that to have the best opportunity to heal, survivors must feel safe to disclose and receive support that is non-stigmatising, appropriate to their needs and effective. Practitioners should have access to the best available evidence, and programs should be evaluated to continuously drive improvement. In order to sustain the current momentum for change, ongoing national leadership is necessary.

In this chapter we recommend the establishment of a national centre dedicated to reducing stigma, promoting help-seeking and building and translating evidence to inform the ongoing development of best practice advocacy and support and therapeutic treatment services.

### 6.2 Reducing stigma

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As discussed in Chapter 4, stigma surrounding child sexual abuse can lead survivors to feel shame, embarrassment, fear and distrust when contemplating disclosure and seeking support. This was highlighted throughout our inquiry. Volume 3, *Impacts* discusses the constant and deep-seated feelings of shame that many survivors described to us. Volume 4, *Identifying and disclosing child sexual abuse* explains how shame and stigma are significant barriers to disclosure and recovery. Volume 6, *Making institutions child safe* discusses how stigma increases the risk of further victimisation by censoring open, informed discussion and education.

Many survivors told us in private sessions that it was the Royal Commission that encouraged them to speak out and seek support.<sup>5</sup> It is important that approaches to reduce the impact of stigma continue beyond the Royal Commission. In the *Nature, cause and impact of child sexual abuse* public hearing, Dr Gary Foster told us that:

as a practitioner, the messaging we need to get out is that there is hope. That's one of the things I'm really concerned about ... That's what this Commission has been all about, and that's the job for all of us from now on.<sup>6</sup>

Myths about child sexual abuse remain in the community and across service sectors. Victims and survivors often choose not to disclose due to a prevailing culture of disbelief and ignorance about child sexual abuse.<sup>7</sup> We are concerned that there may still be a lack of awareness in the community, including among professionals, about what constitutes child sexual abuse.<sup>8</sup> As a result, victims could experience unhelpful service responses from professionals who do not understand the issues. As discussed in Chapter 4, this has led to ineffective practices in recognising and responding to child sexual abuse and related trauma.

Stigma can create profound barriers that prevent people from seeking help.<sup>9</sup> Addressing stigmatising attitudes about child sexual abuse among the broader community would support victims and survivors to seek help.<sup>10</sup>

### 6.2.1 Approaches to reducing stigma

Australian governments have committed to strategies for reducing stigma in a number of policy areas, particularly in the mental health sector.<sup>11</sup> Stigma reduction campaigns aim to undermine negative perceptions and stop discrimination that can prevent people seeking help.<sup>12</sup> SANE Australia argues that a national strategy to address stigma is fundamental to any broader program and policy framework on mental health.<sup>13</sup> While population-wide anti-stigma campaigns are difficult to evaluate, the national organisation *beyondblue* offers a successful model for such campaigns, having demonstrated success in reducing stigma and increasing awareness of depression.<sup>14</sup>

Two intervention strategies to reduce stigma around mental illness show promise. First, education can build understanding and dispel myths around the issue. Second, interventions that allow for direct contact with the stigmatised person or group can put a human face to the issue and foster empathy. These methods may be effective in a variety of contexts.<sup>15</sup>

One review of 14 experimental and quasi-experimental studies into stigma reduction related to mental illness stated:

Educational and contact-based strategies toward developing stigma reduction programs were found to be promising and effective approaches for achieving the most sustained knowledge gain or positive attitudinal behavioural changes needed to decrease the stigma associated with mental illness.<sup>16</sup>

A review of national anti-discrimination and social inclusion programs addressing mental health in five English-speaking countries identified promising practice principles for delivering such programs.<sup>17</sup> These included promoting a simple, enduring national vision, planning strategically at the national level across multiple sectors and supporting local program delivery. The review also identified ways to empower people living with mental health issues, such as providing peer-led supports, targeting messages to key groups, utilising media and social marketing, and prioritising research and evaluation.<sup>18</sup>

Our private roundtable on advocacy and support and therapeutic treatment considered a national approach to destigmatising child sexual abuse. Academic, government and non-government participants agreed that it was the most promising way to address the social attitudes and beliefs that undermined effective responses to child sexual abuse.<sup>19</sup> The current national agenda to reduce the stigma surrounding domestic violence was identified as an example of the benefits of a national approach rather than separate state-based projects.<sup>20</sup> In written submissions to *Issues paper 10: Advocacy and support and therapeutic treatment services (Advocacy and support and therapeutic treatment services)*, individual victims and survivors told us they felt it was time to have a national campaign about child sexual abuse.<sup>21</sup> Survivor support services also recommended public campaigns to raise awareness of child sexual abuse and address the impacts of trauma.<sup>22</sup>

A national approach to overcoming the stigma and discriminatory attitudes surrounding child sexual abuse would help lift the burden of shame and self-blame carried by so many victims and survivors, remove barriers to disclosure and help-seeking, and support greater understanding by practitioners within services.

## 6.3 Supporting good practice

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The evidence and information discussed in this volume confirm that, in order to respond effectively to the needs of victims and survivors, service providers should understand the impacts of child sexual abuse, know how to respond appropriately to trauma, and be able to work flexibly and collaboratively.

In Chapter 4 we presented information that demonstrates this was not always the case in the current service system. In Section 4.3 we referred to private sessions, research and numerous submissions informing us that many current service providers lacked sufficient knowledge of the impacts of child sexual abuse. Additionally, while there was a generally shared understanding of the principles of a trauma-informed approach in Australia, work was needed to help translate this into everyday practice:

The emergent and enthusiastic take-up of the idea of trauma-informed care would be significantly strengthened through national leadership and collaborative initiatives to design, implement and evaluate organisational and systemic approaches.<sup>23</sup>

Participants at our private roundtable on advocacy and support and therapeutic treatment told us that a significant gap existed between what was known about the impacts of trauma and effective approaches to recovery and the translation of this knowledge into service responses.<sup>24</sup> The Australian mental health commissions have consensus that a need exists to ‘build trauma capability across the full spectrum of services ... to identify, support and appropriately refer survivors of child sexual abuse’.<sup>25</sup>

In Section 4.4.1 we discussed workforce issues that impeded implementation of good practice, including a lack of accessible education and training, practice standards and professional supervision. Commissioned research suggested that there were limited resources available to guide practitioners on the delivery of trauma-informed care and in particular to demonstrate how whole organisations and service systems could be trauma-informed.<sup>26</sup>

Work is needed to disseminate and facilitate the uptake of the latest evidence on child sexual abuse and encourage services to put trauma-informed approaches into practice. Different approaches to ‘knowledge translation’ have predominantly been used in the field of health policy, but are increasingly being applied in other sectors such as domestic violence,<sup>27</sup> family services,<sup>28</sup> and trauma treatment for victims of child sexual abuse.<sup>29</sup> Evidence from implementation research suggests that ‘interactive strategies’ to disseminate knowledge may help break down barriers to the uptake of new knowledge, and these strategies could be brought to bear on this issue.<sup>30</sup>

### 6.3.1 Education and training

The skills and knowledge required to provide advocacy and support and therapeutic treatment services are largely taught as components of formal qualifications in tertiary education institutions, including universities and the vocational education and training sector. We were told by several stakeholders – including specialist sexual assault services, academics and survivor advocacy groups – that Australian tertiary curricula in fields such as clinical psychology, psychiatry and social work did not adequately equip graduates to respond to issues related to child sexual abuse and trauma.<sup>31</sup>

There is a need for specific training and education on trauma-informed care. Participants at our private roundtable on advocacy and support and therapeutic treatment told us that the vast majority of people who provided services to victims and survivors had not received this type of training.<sup>32</sup> We were told there was limited trauma education in universities and vocational training programs and very little training overall that was culturally appropriate for Aboriginal and Torres Strait Islander staff.<sup>33</sup>

Stakeholders told us that the inclusion of child sexual abuse and trauma-informed care in tertiary education programs was essential for creating a trauma-informed workforce<sup>34</sup> and that general skills for understanding and responding to trauma should be taught within relevant

university courses.<sup>35</sup> The South Australian Government recommended education at a graduate and postgraduate level as one way to upskill practitioners and staff.<sup>36</sup> The Blue Knot Foundation recommended in a submission to us that people who are studying to be primary health practitioners be specifically trained to identify the cumulative effects of trauma.<sup>37</sup>

The consequence of staff in mainstream services failing to understand victims' and survivors' communication and reactions in the context of their childhood trauma is that survivors may withdraw from seeking assistance, which has the potential to exacerbate their mental and physical health issues.<sup>38</sup> Participants in our private roundtable on advocacy and support and therapeutic treatment generally agreed that the broad human services workforce should have an understanding of trauma,<sup>39</sup> with some participants proposing national standardisation and a national system of accountability.<sup>40</sup> They also recommended more advanced trauma specialisation programs within social work or psychology degrees that would target people intending to work in therapeutic settings.<sup>41</sup>

We acknowledge that changes to curricula pose many challenges and may require the support of a range of bodies. Different sectors, professions and accreditation bodies would be required to review qualifications for the multitude of relevant job roles that may require this education and training. For this reason we did not investigate the details of curricula review, but have raised the issue for consideration.

Beyond formal qualifications, professional development of staff through in-service training and ongoing external professional supervision for clinicians can improve understanding of child sexual abuse and trauma-informed care. Consistent with commissioned research,<sup>42</sup> many organisations indicated in their submissions to us that trauma-informed care is an important principle underpinning effective service responses for victims and survivors of child sexual abuse.<sup>43</sup> Training and education in trauma and appropriate responses should be available for the range of services where victims and survivors seek help. This includes mental health, alcohol and other drugs, specialist sexual assault, aged care and community-based services as well as youth justice and adult detention settings.

Specialist practitioners providing therapeutic treatment should also be adequately trained, qualified and experienced in working with child sexual abuse and complex trauma, and be culturally competent and capable of working with people with disability.<sup>44</sup> They should have access to ongoing trauma-informed education and training to maintain skills and expertise.<sup>45</sup>

In some jurisdictions, work is underway that could be considered when designing broader approaches to developing a trauma-informed workforce. The Victorian Government's mental health workforce strategy, which is focused on building a skilled mental health workforce,<sup>46</sup> calls for 'high-quality state-wide training and support' to 'support organisations and their workforces to better respond to trauma'.<sup>47</sup> At our private roundtable on advocacy and support and therapeutic treatment we also heard about training in trauma-informed service delivery being provided to all staff in Corrective Services NSW.<sup>48</sup>

### 6.3.2 Practice guidelines and professional supervision

Several service providers told us about the need for practice guidelines and standards to support the work being undertaken in the fields of child sexual abuse and trauma.<sup>49</sup> Practice guidelines would support the translation of current evidence into everyday practice.<sup>50</sup> They could be used as a benchmark for best practice to improve quality of care, provide clinical direction and to support accountability and consistency of services. Such guidelines could address inconsistencies and support specialist sexual assault practice.

In Section 4.4.1 we outlined our consultation with specialists and mainstream services regarding appropriate best practice principles and the need for guidelines. A number of agencies endorsed the *Practice guidelines for treatment of complex trauma and trauma-informed care and service delivery* published by the Blue Knot Foundation in 2012.<sup>51</sup>

It is important that any practice guidelines adopted reflect appropriate practice for the range of staff engaging with victims and survivors of child sexual abuse. Research we commissioned asked:

how do a receptionist, child protection worker, nurse, supervisor, cleaner, support worker and educator 'do' trauma-informed care? There are likely to be differences depending on an individual's role, which is to be expected and appropriate. Analysis suggests that workers may need concrete strategies and tools to embed trauma-informed care in their roles.<sup>52</sup>

National coordination of high-quality material that translates the latest evidence into tools for practice or learning guides for educational purposes would support the implementation of trauma-informed service systems for victims and survivors. We are satisfied there is a need for national leadership in this area.

We heard from specialist sexual assault services and other providers that professionals involved in providing therapeutic treatment services should have access to regular external professional supervision.<sup>53</sup> External professional supervision is an important means of educating, supporting and providing accountability for professional practice and underpins the effective implementation of practice guidelines.<sup>54</sup> Supervision also mitigates the risks posed by vicarious trauma and can help retain workers in the field.<sup>55</sup>

Professional supervision is essential for an effective workforce and should be included in workforce standards.



## 6.4 Supporting the development and dissemination of evidence

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Although evidence on what constitutes effective practice in advocacy and support and therapeutic treatment for victims and survivors of child sexual abuse is growing, it is still limited. We are of the view that an authoritative source of information on proven and promising practice is required. This would promote best practice and guide policy makers, funding bodies and service providers in 'what works' to achieve better health and wellbeing outcomes for victims and survivors.

Our research program has added to the current evidence base on the causes and effects of child sexual abuse in institutional contexts. Our published research has addressed gaps in knowledge regarding the impacts of child sexual abuse across the life course and will 'help to develop a much more holistic understanding of how the experience of child sexual abuse in institutions resonates throughout the life of the victim/survivor'.<sup>56</sup> However, there is limited evidence of outcomes for promising models of service intervention,<sup>57</sup> particularly for victims and survivors of child sexual abuse in institutional contexts.<sup>58</sup> A better understanding of how to effectively provide therapeutic treatment approaches for different population groups is required.<sup>59</sup>

Although healing programs for Aboriginal and Torres Strait Islander communities are widely supported, few of these have been formally evaluated.<sup>60</sup> Services for victims and survivors with disability are scarce and there is little evidence on the best treatments and supports.<sup>61</sup> Evaluations of sexual assault service delivery in general are also required, to better meet the needs of all victims and survivors.<sup>62</sup> There is a particular need for further applied research into effective therapeutic treatment for children.<sup>63</sup>

In Australia, trauma-informed care is an emerging field. Skills and knowledge are not as developed as in other parts of the world, particularly the United States.<sup>64</sup> There is very limited research on Australian trauma-informed initiatives, and we do not know the extent to which existing services are trauma-informed.<sup>65</sup> Submissions to our *Advocacy and support and therapeutic treatment services* issues paper noted the importance of evaluations of the effectiveness of trauma-informed treatments and the need to investigate and promote how services might better recognise and respond to particular victims and survivors.<sup>66</sup>

Australia does not have a central repository of information about current practice in trauma-informed care. This means the picture of what is happening in service systems is unclear and fragmented.<sup>67</sup> Our commissioned research suggests that, in the absence of strong, collaborative national leadership, the development of trauma-informed care models is driven in an ad hoc manner by individual services rather than through a systematic process:

Practice wisdom and evaluation knowledge have not yet coalesced sufficiently to guide how the principles [of trauma-informed care] are put into practice in different settings ... there is a lack of publicly available, coordinated material on trauma-informed care programs and models being developed and the format they take.<sup>68</sup>

In submissions to our *Advocacy and support and therapeutic treatment services* issues paper, several agencies told us they did not receive funding for evaluation.<sup>69</sup> Some agencies said they wanted to evaluate their services but did not have the capacity;<sup>70</sup> some wanted further funding to enable them to carry out the evaluation.<sup>71</sup> The need for further support to carry out evaluation was echoed by participants at our private roundtable on advocacy and support and therapeutic treatment.<sup>72</sup>

A coordinated national approach is needed for the dissemination and translation of research findings into the area of responding to survivors of child sexual abuse and implementing trauma-informed approaches. There is also a need to improve the capacity of service providers to monitor and evaluate the outcomes of their interventions and provide a mechanism for sharing their results. Creating a centralised place where all services and professionals can access the latest evidence, in usable formats for their service context, would support high-quality implementation and continuous improvement.

## 6.5 A national organisation to reduce stigma, promote help-seeking and support good practice

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Efforts to address the stigma surrounding child sexual abuse and improve service quality should be underpinned by a single organisation that provides national leadership, building on and disseminating the work already underway in various sectors and jurisdictions.

### 6.5.1 Existing bodies in Australia

There are a number of organisations that currently play a role in driving stigma reduction, knowledge translation and research agendas in relation to health and social issues. Many such organisations are state- or territory-based, but Australia has a history of creating national organisations for particular issues. These organisations are generally collaborative in nature, linking public and private institutions with the aim of pursuing strategic goals. National organisations have a range of funding sources, including the Australian Government, state and territory governments, and philanthropic donations. While many state, territory and national organisations perform similar functions in related fields, no single national organisation leads work focused on responding to the stigma surrounding child sexual abuse and promoting best practice to improve outcomes for children and adults who have experienced such abuse.

The Australian Government funds statutory research and advisory bodies to inform practice and policy on a range of issues. The Australian Institute of Family Studies (AIFS) was established in 1980 to promote – through research and dissemination of the findings – an understanding of the social factors that affect how Australian families function.<sup>73</sup> The AIFS also manages Child Family Community Australia, an information exchange body that provides evidence-based

resources for practitioners and policymakers working with children and families.<sup>74</sup> In the 2015–16 financial year, AIFS received approximately \$4.6 million in government funding in addition to almost \$7.5 million in revenue from the sale of goods and services.<sup>75</sup>

The Australian Institute of Health and Welfare (AIHW) was established by the Australian Government to provide information and statistics on the health and welfare of Australia's population in a wide range of areas.<sup>76</sup> Data provided by AIHW is used by governments and the community to assist in making policy decisions on health, housing and community services matters.<sup>77</sup> In the 2015–16 financial year, AIHW received approximately \$15.6 million in government funding and an additional \$31.3 million in revenue for project work for external agencies.<sup>78</sup>

The Productivity Commission is the Australian Government's independent agency providing research and advice to government on economic, social and environmental issues affecting the welfare of Australians.<sup>79</sup> In the 2015–16 financial year, the Productivity Commission received approximately \$32.9 million in government funding.<sup>80</sup>

A number of national organisations have been established by Australian governments to focus on a specific health or social issue. In October 2000, Australian governments established *beyondblue* 'within the context of a growing international awareness of the huge burden of disability associated with illnesses such as depression'.<sup>81</sup> In its first year of operations, *beyondblue* was allocated \$4.8 million by the Australian Government and state and territory governments, and was focused on bringing together expertise from across the country, leading improvements and building capacity at a national level. This included programs to remove stigma, improve community understanding, develop health service responses and promote innovation through research and development.<sup>82</sup> In its first year, *beyondblue* conducted community awareness activities about depression through media, community partnerships and the rollout of a website and educational programs.<sup>83</sup> A number of national anti-depression projects were initiated, research was undertaken in a range of different contexts and *beyondblue* contributed to national mental health policy.<sup>84</sup>

Participants in our private roundtable on advocacy and support and therapeutic treatment identified *beyondblue* as a good example of what can be achieved by an independent body at a national level in addressing a key social issue.<sup>85</sup> These achievements were identified as influencing national policy, organising research and reducing the stigma and discrimination associated with a social issue (depression) with the support of all governments.<sup>86</sup> A recent independent evaluation of *beyondblue* found that the organisation had made progress in the key areas for which it was established: knowledge development, reduction of stigma and building of understanding.<sup>87</sup> Since its inception, *beyondblue* has added the issues of anxiety and suicide prevention to its scope of work, and has implemented a program of support services provision. In the 2014–15 financial year, the organisation received core funding of \$9.1 million from the Australian Government and \$6.4 million from state and territory governments.<sup>88</sup>

Other national organisations that address social issues include The National Centre of Excellence in Youth Mental Health (Orygen), and Australia's National Research Organisation for Women's Safety (ANROWS). ANROWS was established under the National Plan to Reduce Violence against Women and their Children 2010–2022.<sup>89</sup> It aims to fill knowledge and research gaps on violence against women and children, bringing together existing research and undertaking new research in a coordinated national approach relevant to policymakers and service providers.<sup>90</sup> ANROWS also aims to increase understanding of violence against women and children across key sectors such as health, justice, education and housing.<sup>91</sup> In 2015, the Australian Government's national inquiry into domestic violence concluded that ANROWS was effective not only in addressing gaps in knowledge through its research program, but also in increasing understanding of the key issues.<sup>92</sup> ANROWS' core funding of \$3 million a year from 1 July 2013 to 30 June 2016 was provided by contributions from the Australian Government and state and territory governments.<sup>93</sup> In addition, the Australian Government provided a one-off establishment grant of \$1 million and a further \$1 million a year for three years for research on interventions with perpetrators of violence against women and their children.<sup>94</sup> The Victorian Government provided a grant of \$500,000 to produce a family violence index.<sup>95</sup> In the 2015–16 financial year, ANROWS received approximately \$5.6 million in grants.<sup>96</sup>

A range of academic institutions, including universities and the Australian Research Council's Centres for Excellence, perform research functions on the issue of child sexual abuse, but do not focus on reducing stigma or improving service quality for victims and survivors of child sexual abuse. The Blue Knot Foundation is a national organisation established to empower survivors of childhood trauma in their recovery, but is not solely focused on child sexual abuse.

In Volume 6, *Making institutions child safe* we recommend the creation of a National Office for Child Safety. This national office would be located in the Commonwealth Department of the Prime Minister and Cabinet and would provide leadership for all national initiatives related to child safety. While this national office would focus on child safety policy, our recommended national centre would seek to improve advocacy and support and therapeutic treatment services for victims and survivors of child sexual abuse. We envisage strong links between these two national bodies.

Currently, no agency has a specific focus either on stigma reduction or on research and knowledge translation regarding the needs of children and adults who experienced sexual abuse in childhood. As a result, the issue falls through the gaps. There is a clear need for an entity to drive stigma reduction, promote help-seeking and support best practice to improve outcomes for victims and survivors.

## 6.5.2 International examples

A number of international centres have been established and currently function to promote positive outcomes for service users. While they do not have a specific focus on victims and survivors of child sexual abuse, they do demonstrate how centralised entities in other jurisdictions may drive system-wide policy and practice improvements.

The trauma-informed movement in the United States has been driven by central bodies such as Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA leads efforts to incorporate trauma-informed theory and practice into mental health services and is a key resource for trauma-informed approaches to care.<sup>97</sup> In the last decade, work on trauma-informed child and family service systems has been further developed in the US through ongoing leadership from SAMHSA, in the form of funding, resources and guidance material, through the establishment of the National Center for Trauma-Informed Care (NCTIC), and through the development of resources such as guidelines, toolkits, websites and training material.<sup>98</sup> SAMHSA also funds the National Child Traumatic Stress Initiative to develop a shared language and evidence base around trauma and trauma-informed approaches within a range of services.<sup>99</sup> Australia has no equivalent to SAMHSA or the NCTIC.<sup>100</sup>

In the United Kingdom, the Anna Freud National Centre for Children and Families is focused on working with children, young people with mental health issues and their families.<sup>101</sup> The centre advances practice through undertaking research, developing training, taking a lead role in policy, collaborating and sharing knowledge and resources.<sup>102</sup> Following the release in 2015 of a national report into children's and young people's mental health and wellbeing,<sup>103</sup> the Anna Freud National Centre committed to a new centre for excellence to address some of the key recommendations for improving mental health services for children, young people and their families. To be launched in 2018, the new centre will create a hub of research and practice; establish a policy forum; integrate mental health, education, social care and research under one roof; deliver postgraduate programs; and provide information for child mental health research and practice.<sup>104</sup>

## 6.5.3 A national centre dedicated to stigma reduction and practice reform

Our analysis of submissions, the policy and research work we have conducted and the consultations we undertook support the conclusion that a dedicated agency is needed to provide national leadership and to drive practice and policy improvement for victims and survivors of child sexual abuse. Victims and survivors would benefit from an organisation that is adequately resourced and that has the authority to focus on the impacts of child sexual abuse. This organisation should have three core functions:

- to undertake strategic awareness raising and stigma reduction activities to foster help-seeking behaviours
- to provide national leadership in knowledge translation by promoting best practice in education and training and by promoting nationally consistent practice guidelines
- to promote strategically important research and evaluation to address gaps in knowledge.

To this end, we recommend the creation of a national centre for children and adults who experienced sexual abuse in childhood.

It is our view that the community would be best serviced if the national centre were to focus on stigma reduction, the promotion of best practice through knowledge translation, and the development and dissemination of evidence around child sexual abuse in all contexts. Many of the issues to be canvassed by the proposed national centre, in responding to the impacts and trauma of child sexual abuse, have application to all survivors of child sexual abuse. Importantly, in relation to the organisation's core functions of reducing stigma and maintaining a public profile, we are of the view that a distinction between institutional and non-institutional child sexual abuse would be neither practical nor desirable. In addition, service improvements are needed in mainstream and specialist services that respond to the needs of all victims and survivors. The overall scope of a national centre should be focused on child sexual abuse generally, but should also include a key focus on developing best practice responses to the impacts of child sexual abuse in institutional contexts.

## Core functions

The national centre should take steps to reduce stigma surrounding child sexual abuse. Throughout our inquiry we have heard of the negative impact of stigma, as discussed in Section 4.2.1 and Section 6.2. We have been told that the establishment and existence of the Royal Commission – and its prominence in the media – has itself been effective in reducing stigma. The completion of the Royal Commission will create a gap in national leadership in this area. Raising awareness and promoting destigmatising messages about the impacts of child sexual abuse should be a core function of the national centre. The national website recommended in Section 5.3.3 could play a role in stigma reduction. There is potential for the national centre to have an oversight role for the national website proposed in Recommendation 9.5.

The national centre should seek to improve service quality by strategically influencing front-line practice. As discussed in Section 6.3, three areas present opportunities to strategically promote best practice. First, the national centre should engage with tertiary education providers to ensure that relevant curricula provide students and graduates with an awareness of issues around child sexual abuse and complex trauma. This is particularly important in clinical psychology, medicine and social work degrees. Second, the national centre should engage with

training providers to develop trauma training modules for mainstream and specialist agencies and professionals seeking to become trauma-informed. Third, the national centre should foster best practice by developing trauma-related practice standards for services responding to victims and survivors of child sexual abuse.

The national centre should promote best practice by supporting the development and dissemination of practice knowledge. It should highlight gaps in evidence related to the experiences of victims and survivors of child sexual abuse and outcomes of advocacy and support and therapeutic treatment interventions. The national centre should particularly focus on the outcomes for, and experiences of, different population groups. In addition, the national centre should strategically disseminate high-quality research findings that have a bearing on front-line practice.

## Funding

The national centre should be funded by the Australian Government in conjunction with state and territory governments. While we believe that the national centre should be established jointly by all jurisdictions, we recognise negotiations may take time. The national centre should be established as soon as possible to ensure work on stigma reduction can maintain the momentum created by the Royal Commission and that services can access up-to-date information to support best practice responses to victims and survivors. Irrespective of negotiations between state and territory governments, the Australian Government should immediately establish the national centre.

To promote innovation and emerging best practice, the national centre should be able to access multiple sources of funding and not be solely dependent on government funding.

We spoke with a range of national organisations with similar functions to discuss costs of undertaking community awareness and stigma reduction, research and evaluation, and knowledge translation functions. Taking into consideration the resourcing of similar organisations in other fields, discussed in section 6.5.1, it is likely an initial five-year investment of \$45 million would provide adequate resources for the national centre to be established and successfully achieve its initial priorities. This investment should supplement any resources allocated to the delivery of direct services by service providers.



## Structure

The national centre should have a governance structure that makes it operationally independent of government. However, it should establish partnerships with governments to ensure that it is responsive to emerging policy needs.

The national centre should include in its governance structure mechanisms to ensure participation by victims and survivors of child sexual abuse. It should create opportunities for survivors to take leading roles in advocacy, evaluation, organisational governance and community education. Close partnerships with service providers would also be crucial for the success of knowledge translation. The national centre should work with other organisations collaboratively, acknowledging expertise around Australia.

### **Recommendation 9.9**

The Australian Government, in conjunction with state and territory governments, should establish and fund a national centre to raise awareness and understanding of the impacts of child sexual abuse, support help-seeking and guide best practice advocacy and support and therapeutic treatment. The national centre's functions should be to:

- a. raise community awareness and promote destigmatising messages about the impacts of child sexual abuse
- b. increase practitioners' knowledge and competence in responding to child and adult victims and survivors by translating knowledge about the impacts of child sexual abuse and the evidence on effective responses into practice and policy. This should include activities to:
  - i. identify, translate and promote research in easily available and accessible formats for advocacy and support and therapeutic treatment practitioners
  - ii. produce national training materials and best practice clinical resources
  - iii. partner with training organisations to conduct training and workforce development programs
  - iv. influence national tertiary curricula to incorporate child sexual abuse and trauma-informed care
  - v. inform government policy making
- c. lead the development of better service models and interventions through coordinating a national research agenda and conducting high quality program evaluation.

The national centre should partner with survivors in all its work, valuing their knowledge and experience.

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