RESPONSE TO CONSULTATION PAPER: REDRESS AND CIVIL LITIGATION

CANBERRA RAPE CRISIS CENTRE

This paper is a response to the Consultation Paper on *Redress and civil litigation* from the Canberra Rape Crisis Centre (CRCC) and its male survivor's service SAMSSA (Service Assisting Male Survivors of Sexual Assault). The CRCC provides counselling and support to women and children who have experienced recent or historical sexual assault and are living in the Canberra region, and their supporters. SAMSSA provides counselling and support to male survivors of sexual assault and their supporters. SAMSSA is a programme of the CRCC.

The CRCC has been in operation in the ACT since 1976 and is a provider of the Australian Government-funded Royal Commission Community-Based Support Services for the Canberra region.

The bulk of our comments are in relation to Chapter Five of the Consultation Paper, which addresses counselling and psychological care for survivors of institutional child sexual abuse. We have also made some short comments in relation to some of the other issues raised in the Consultation Paper.

Our comments are based on our clinical experience working with survivors of child sexual assault for close to forty years, and on recent research into trauma-informed care and treatment. Our experience is as front-line practitioners and clinicians, and this is the perspective from which we have written this response.

Structural issues

The CRCC endorses the principle outlined in the Consultation Paper of fairness in the sense of equal access and treatment. We can affirm from our own experience how important this is to survivors (and how rarely they have received it from the institutions where their abuse took place).

We also endorse the idea that while abuse is obviously primarily the responsibility of the individual abuser and the institution which failed to respond appropriately, there is a larger, societal responsibility which must form part of the of the redress effort.

The CRCC supports the following principles for providing redress to survivors of child sexual abuse in institutions:

- Redress should be about justice for the survivor.
- There should be 'no wrong door' for access to redress.
- All offers and assessments should be based on current research and best practice (we speak more about trauma-informed care below).
- Redress processes should take into account the needs of vulnerable and disadvantaged survivors.
- Ideally, there should be a single national redress scheme.

In addition, we would recommend the following principles:

- The redress system should be safe for survivors – it should not operate in such a way as to re-traumatise survivors or inadvertently do harm.
- The redress system should be highly respectful of survivors and their experiences.

- Interactions with survivors should be based on the assumption that the survivor's presenting 'pathology' is rational and was originally adaptive. Many of the problems of adulthood stem from coping strategies that were originally protective attempts to deal with childhood trauma.

Direct personal response

We agree that a direct personal response from the institution would be welcome to many survivors and should certainly be available to any survivor who wants it. We endorse the following principles:

- A personal response should only occur if the survivor requires it.
- The response should be focused on acknowledging the survivor's experience, accepting responsibility, and explaining to the survivor what has been done to deal with the possibility of future child abuse.
- There must be no element of justification, explanation, or excuse. There must be no discussion of the 'contributing responsibility' of the survivor.
- The response should be delivered by who have received appropriate training. Such training should not, as a general rule, be developed or delivered from within the institution.

Counselling and psychological care

Child sexual abuse

Child sexual assault is a significant issue in Australia (Fergus & Keel, 2005; Tarczon & Quadara, 2012). Within the CRCC, around 50% of our female clients, and 90% of our male clients, are adult survivors of child sexual abuse.

The impacts of child sexual abuse can be varied and complex, as pointed out in the Consultation Paper (pages 107-108), and can run the range of adult psychopathology (Briere & Scott, 2013; Kezelman & Stavropoulos, 2012; Ross & Halpern, 2009). At CRCC and SAMSSA, adult survivors of child sexual abuse tend not to seek support directly in relation to their abuse, but rather in response to a crisis in the long-term strategy/ies they have adapted in relation to their abuse. Examples include substance abuse, dissociation, violence, dysfunctional relationship styles, and so on. Many adult survivors of child abuse have very chaotic lives and may suffer from a range of social problems including poverty, homelessness, violence, difficulties in parenting, difficulties with relationships, and so on.

In working with survivors, we assume that the presenting 'pathology' is rational and was originally adaptive, even if only in the immediate term. Many of the problems of adulthood stem from coping strategies that were originally protective attempts to deal with the trauma.

CRCC counsellors do not make formal diagnoses, although we do have regard to the broad category of *DSM-V* Disorders into which the client seems to fit. However, survivors of complex trauma will often come to us with previously made formal diagnoses. These include schizophrenia or other psychotic disorders, bipolar disorders, depression, anxiety, addictive disorders or frank substance addiction, eating disorders, somatic disorders, dissociative experiences, sleeping disorders, sexual dysfunction, and personality disorders (particularly Borderline Personality Disorder). Survivors will

often have been given more than one of these diagnoses in the past, depending on their circumstances and the part of the mental health system they dealt with. A usual 'cluster' of diagnoses for one of our clients is a psychotic disorder, depression and anxiety, and at least one personality disorder.

The fundamental aetiology of all these phenomena is usually the developmental damage caused by childhood trauma (Briere & Scott, 2013; Ross & Halpern, 2009). When the abuse occurs in critical periods of development, it can profoundly damage psychobiological, social and emotional development. The disorders and syndromes we see are, in actuality, often second-order effects.

The very wide numbers of disorders that child abuse survivors suffer from is, in our view, a function of the fact that child abuse affects most aspects of the child's development. From our point of view, what we usually see is a combination of all or most of the following: phobic anxiety, affect dysregulation, dissociative disorders, somatic dysregulation, impaired self-development and self-concept, and problems with attachment/relationships.

Counselling services

We would like to affirm the importance the Consultation Paper has attached to counselling and psychological support for survivors of institutional child abuse. Effective counselling can address underlying trauma-linked implicit memories and associated phobic responses and help clients achieve emotional regulation and integration and more secure attachment/relationship patterns (Briere & Scott, 2013; Herman, 1997; Ogden, Minton & Pain, 2006).

But we would like to emphasise that counselling for survivors of child sexual abuse will only be effective if it is delivered from a trauma-informed perspective (Kezelman & Stavropoulos, 2012), and is supported by a strong professional structure including a practitioner development framework based on current research, regular professional supervision, and access to support for vicarious trauma. This can sometimes be an issue in terms of resources and is discussed further below (see 'Service gaps'). CRCC endorses and as far as possible works within the Practice Guidelines for treatment of complex trauma developed by ASCA (Kezelman & Stavropoulos, 2012).

We endorse the idea in the Consultation Paper that counselling will often be long-term and intermittent. While all sexual assault has the potential to create significant post-traumatic responses, in our experience there is a significant difference in the level of expertise and time required to work with a survivor of child abuse.

Survivors can benefit from counselling at any point in their lives, depending on their circumstances and the stage of recovery from abuse in which they find themselves. We use as a framework the three-phase Trauma Model for working with survivors of trauma first developed by Herman (1997) and now widely accepted:

1. *Establishing safety*
2. *Processing ('Mourning')*
3. *Integration ('Reconnection')*

The different phases of treatment and recovery involve different needs and different psychological tasks. In the first phase, survivors deal with containing/reducing dangerous strategies (including self-

harm and suicide), develop basic skills for managing intrusive memories, nightmares, and panic attacks, learn now to notice and manage affective triggers, develop affect tolerance and management skills, and develop tolerance to phobic responses to abuse memories and accept strong feelings. In the second phase, the survivor processes and expresses the feelings related to the abuse and makes new meaning from his/her experience. In the third phase, the survivor develops skills for independent living, forms new relationships or re-connects with old ones, and begins to feel more securely attached to others (Herman, 1997). During any of the phases the survivor may be triggered by external events, parenting or family issues, significant anniversaries, health problems, or new trauma, and may find him/herself either 'returning' to earlier psychological tasks or needing extra support for the work in the current phase. While the survivor would be expected to be in a much better place to manage the new difficulty in Phase Three as opposed to Phase One, some support may still be required.

The CRCC supports the suggestion in the Consultation Paper that there should be no fixed limits on the number of counselling sessions a survivor might access. Complex trauma can take many years to be effectively managed, depending on the severity of the abuse and the complexity of post-traumatic strategies adopted by the survivor. Having a cap on the amount of counselling available can make it impossible to address some of the more complex impacts of trauma, which in turn places strains on other services such as the mental health system, drug and alcohol treatment services, family relationship services and so on.

Having said this, counselling needs planning, a focus on measurable outcomes, and regular review as part of best practice (Briere & Scott, 2013; Kezelman & Stavropoulos, 2012). Wandering, unfocused counselling is of limited benefit to survivors and can entrench them in their 'trauma narratives' (O'Leary, 1999).

In summary, the CRCC supports the following principles in relation to the provision of counselling to survivors of institutional child sexual abuse:

- Counselling should be available throughout a survivor's life.
- Counselling should be available on an episodic basis.
- Survivors should be allowed flexibility and choice.
- There should be no fixed limits on counselling services.
- There should be suitable assessment and review of individual counselling plans.
- Counselling services should be provided by practitioners with appropriate trauma-informed training, clinical supervision and support, within a supportive professional framework.

Services for family/supporters

We note the discussion of services for family members/partners of survivors at pages 116-117 of the Consultation Paper.

We work regularly with supporters and have found that this is often of great benefit to the survivor. However we have also found that because of the impact of the abuse on the behaviour of survivors, their family members often require support in their own right. The CRCC's view is that partners or family members who are supporting survivors can be, in effect. 'secondary victims' of the abuse and also deserve support.

These issues can be more acute for female partners/supporters of male survivors, as male survivors often have difficulties with relationships and/or use aggressive behaviour or violence within relationships.

Supporters have two needs: information/psychoeducation about the impacts and effects of child sexual assault, and support with the impact the survivor's way of coping with the assault has had on the relationship. The first need is always present and the second is usually present.

It is our view that as a matter of natural justice, the redress system ought to provide:

- Information and psychoeducation to family/supporters of survivors. This will need to be provided by a specialist in sexual assault and trauma-informed practice.
- Where the abuse has contributed to negative behaviours on the part of the survivor, and the family member has been impacted on by these behaviours, longer-term counselling and psychological care (and/or referral to crisis intervention services).

Service gaps

We can confirm from our own experience many of the service gaps identified in Section 5.4 of the Consultation Paper. In terms of resource limitations of specialist services such as our own, in addition to those described in the Paper we would add the cost of appropriate training and professional development. Specialist sexual assault services, including the CRCC, are largely funded by State and Territory governments as part of the community/not-for-profit sector (Little, 2015). As a result, it is difficult for us to attract more highly qualified mental health professionals. At the same time, as acknowledged by the Consultation Paper, existing undergraduate degrees rarely include a strong focus on trauma. Consequently specialist services need to provide much of the professional development workers need to remain up-to-date with complex trauma in-house, and from a limited budget.

Along these lines, while we agree with the suggestion at page 116 of the Paper about the value of an accreditation system, resource constraints may put achieving this level of accreditation out of the financial reach of many existing specialist sexual assault services.

Another key service gap is the availability of services for people living in regional and remote areas. Like many organisations, we do not have the resources or time to travel long distances to see survivors. The same holds true for incarcerated survivors in facilities away from major centres. We do have some clients who travel significant distances to see us, but this is a substantial impost on their time.

A further noticeable gap in the current system is the lack of any affordable inpatient services for people in the acute stages of post-traumatic syndrome other than public mental health services, which in our experience have a variable response to post-traumatic symptoms and dissociative symptoms in particular. Limited-stay inpatient facilities, along the lines of the Trauma & Dissociation Unit at Belmont Private Hospital in Queensland, could achieve a great deal with acute-stage survivors which simply cannot be provided by office-based counselling services.

Another service gap is the difficulty in establishing effective referral networks between specialist sexual assault services and other services or sectors which may, unbeknownst to them, be working with adult survivors of child abuse.

Referral networks are important because, in our experience, adult survivors will often encounter other crisis or welfare services as a result of difficulties caused by their coping strategies. Popular strategies for coping with the long-term impacts of child abuse include alcohol and drug abuse, gambling, compulsive sexual activity, aggressive or risk-taking behaviours, workaholism, self-blame, rumination, rigid beliefs, self-harm and suicide (SAMSSA, 2014). As a result, services/organisations providing addiction services, mental health services, domestic violence services, the criminal justice system and other welfare support agencies often encounter survivors of child sexual abuse. Unless the underlying trauma-linked implicit memories and associated phobic responses are addressed, it is likely that survivors will continue to cycle through and tie up the resources of these services as they fall back on old ways of dealing with their pain in the absence of a viable alternative.

From our experience, there are two issues with referrals to specialist sexual assault services such as our own. The lesser problem is that some services are not aware of the existence or the contact details of specialist services. The 'silo-ing' of welfare support services is a phenomenon which has been noted many times in the literature (Butler, McArthur, Thomson & Winkworth, 2012) and is, of course, a broader issue than just in the sexual assault service sector. However, this is becoming less of an issue due to the Internet and national databases held by such services as 1800-RESPECT.

The greater challenge is the reluctance of many services to raise the question of sexual assault, or childhood trauma generally, with their clients. Not asking the question means not knowing that a referral to a specialist service might be helpful.

This is particularly an issue with services for specific groups such as Indigenous and CALD people.

We attempt to deal with this issue via regular networking and offering training in responding to disclosures of sexual assault, but our resources to do so are limited.

Finally, from the point of view of this service, 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. Rather than each organisation having its own collection of information, a more rational model might be a national website, perhaps run by a central organisation such as the National Association of Services Against Sexual Violence, with a comprehensive collection of information, recent research and links to all relevant services.

Service gaps: male survivors

Research (Crome, 2006; John Jay College of Criminal Justice, 2004; Olgoff, Cutajar, Mann, & Mullen, 2012) and the experience of the Royal Commission indicate that more boys than girls experienced child sexual abuse in institutions.

However there are currently few services in Australia specialising in the provision of service to male survivors of sexual assault, with varying accessibility across the states. There is also a great diversity of service structures such as voluntary services, government-funded bodies and NGOs which greatly vary in service delivery. There are only two dedicated counselling services for male survivors in Australia, SAMSSA and Living Well in Queensland.

Male-specific services are often run from the same organisations as women's and children's services, which can be challenging to manage. Historically, sexual assault support services in Australia were established in response to the reality that sexual violence is a "gendered crime", with the majority of

victims being female and perpetrators male (Foster, Boyd & O'Leary, 2012; Little, 2015). Many existing organisations are based upon feminist models, some excluding men from the organisation completely either as staff or clients, and some experiencing internal and external tensions and concerns when implementing male client services. An existing service recognized for its historical and current expertise in successfully engaging both male and female clients is the South Eastern Centre against Sexual Assault (SECASA) in Victoria.

Common recruitment standards in sexual assault services often preference female staff, with some exclusively employing women. This has led to a lack of male workers in sexual assault services. While it is our experience that many men prefer or are happy to work with female workers, some male survivors will only consider working with male counsellors. There are also difficult security issues in men working with female workers when the man is using or has used violence against women. In our experience the use of violence against women is common in male survivors of child sexual abuse.

We would also argue that while the essential biological processes of trauma are the same for both genders, working with men requires a somewhat different psychological approach. Because of the operation of social models of masculinity (Connell, 2005), men face different barriers to disclosure and discussion of their abuse, deal with a different type of shame and identity disturbance, and process traumatic emotions somewhat differently to women. For instance, men struggle with social shame around definitions of self-reliant masculinity, homophobia, and expectations that male abuse victims will become abusers, are more likely to manage their pain via substance use or violent behaviour, including suicide, and have fewer resources for understanding and processing strong emotions (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; O'Leary, 2001; O'Leary & Barber, 2008; O'Leary & Gould, 2009; Olgoff et al., 2012; Romano & De Luca, 2001). In our experience the skills and expertise required to work successfully with male survivors of child abuse are different in important ways to those required to work with women, and require somewhat different training and support.

Additional resources would certainly be welcome in the sexual assault services sector to provide:

- Training and development, based on current research, on how best to work with male survivors.
- Additional research on the best ways to work with male survivors, particularly from hard-to-reach groups.
- Development of frameworks for working with men in services which do not currently have them.
- The employment of more male workers in the sexual assault service sector.

Options for service provision and funding

The CRCC would not recommend that service provision be linked to the Medicare system. Our experience leads us to agree with some of the points made at page 125 of the Consultation Paper:

- that survivors may not present to GPs in such a way that they can be easily diagnosed (in many cases, the greater the impact of the trauma, the more difficult this is);
- that they will very often be reluctant to disclose their abuse, particularly in a short GP consultation;

- that Medicare programmes tend to be focused on short-term interventions which have been shown to be ineffective for complex trauma (Courtois, 2004; Trask, Walsh, & Dilillo, 2011); and
- for financial reasons – many survivors struggle to hold jobs or have various levels of disability which force them into poverty.

Survivors are also sometimes not best served by the medical system. For instance, traditional medication-based psychiatric care or standard Cognitive Behavioural Therapy will be ineffective unless the survivor has established a degree of internal psychological safety and self-regulation, the work of the first phase of the Trauma Model (Courtois, 2004; Forbes, Creamer, Phelps, Bryant, McFarlane, Devilly, & Newton, 2007: Herman, 1997). In addition, while child sexual abuse very often leads to diagnosable mental health conditions, to focus on the diagnosed condition and away from the traumatic experience can, in our experience, lead to an overemphasis on symptom reduction and retard the survivor's understanding and recovery (Herman, 1997; van der Kolk, 2001).

Our recommendation would be to support service provision via a trust fund to supplement existing services and fill service gaps. The fund should probably be administered by Government, as it is crucial, both in terms of perception and the actuality of the possibility of the abuse of influence, that the use of funding is completely independent of the institutions providing the funding.

We note in this context that the funding of our own service to provide counselling and support to clients of the Royal Commission via the Royal Commission Community-Based Support Services initiative of the Australian Government, managed by the Australian Department of Social Services as part of its Family Relationship Program, has been a smooth and effective way of administering resources.

Monetary payments

We have no comment in relation to this part of the Paper.

Redress scheme processes

The CRCC endorses the following principles for the redress scheme:

- The scheme should not be subject to a fixed closing date. Our experience and that of the research shows that many survivors are not able to speak of their abuse for many years (O'Leary & Barber, 2008).
- The application process should be as simple as possible.
- Decisions about redress must be made by a body independent of the institutions.
- A plausibility test is a more appropriate standard of proof than that used in civil litigation. Where a particular institution, or 'brand' of institutions, has a large number of substantiated allegations of child abuse against it, the standard of proof for the applicant should be lower still.

We would also make the comment that however well designed, redress processes by their nature can be complex, exhausting and triggering for survivors. We endorse the principle of designing the

system in such a way that applicants have access to support and, if necessary, counselling from the earliest stages of the process.

Finally, we would caution against any process where survivors are provided with funds and encouraged to choose their own support service. This would encourage a redistribution of resources within services towards advertising and public relations and away from professionalism. Rather, as many support services as possible should be funded by the redress scheme to be free of charge or of minimal cost.

Funding redress

As a matter of principle we agree that funding must be provided primarily, if not wholly, by the institutions where abuse took place, or the larger group/body that the institutions were part of. This is both a matter of providing visible justice to survivors and their families, and a deterrent to institutions to allow circumstances where abuse can occur.

It is important, both in terms of perception and the actuality of the possibility of the abuse of influence, that redress funding is spent and managed in ways that are completely independent of the institutions – particularly the larger and more influential institutions – providing the funding.

Interim arrangements

We endorse the suggestion that throughout redress processes, institutions could undertake to fund survivors to obtain counselling and psychological care. The need for counselling/care would need to considered independently of the institution, and should not be provided from within the institutions or any affiliated institution.

Civil litigation

We would support the suggestion of removing limitation periods for litigation actions relating to child abuse, for the reasons described under 'Redress scheme processes' above.

The CRCC is appreciative of the opportunity to provide these comments and would like to congratulate the Royal Commission on its just and humane approach to its work and the survivors with whom it has been in contact.

Canberra Rape Crisis Centre Management Group
March 2015

REFERENCES

Briere, J. N., & Scott, C. (2013). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, CA: Sage Publications.

Butler, K., McArthur, M., Thomson, L., & Winkworth, G. (2012). Vulnerable families' use of services: Getting what they need. *Australian Social Work, 65*(4)*,* 571-585.

Connell, R. W. (2005). *Masculinities* (second edition). Crows Nest, NSW: Allen & Unwin.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 412-425.

Crome, S. (2006). *Male survivors of sexual assault and rape* (ACSSA Wrap 2). Melbourne: Australian Centre for the Study of Sexual Assault.

Fergus, L., & Keel, M. (2005). *Adult victim/survivors of childhood sexual assault* (ACSSA Wrap 1). Melbourne: Australian Centre for the Study of Sexual Assault.

Forbes, D., Creamer, M., Phelps, A., Bryant, R., McFarlane, A., Devilly, G. J., & Newton, S. (2007). Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. *Australasian Psychiatry*, *41*(8), 637-648.

Foster, G., Boyd, C., & O'Leary, P. (2012). *Improving policy and practice responses for men sexually abused in childhood* (ACSSA Wrap 12). Melbourne: Australian Centre for the Study of Sexual Assault.

Herman, J. (1997). *Trauma and recovery.* New York, NY: Basic Books.

John Jay College of Criminal Justice. (2004). *The nature and scope of the problem of the sexual abuse of minors by Catholic priests and deacons in the United States.* New York: US Conference of Catholic Bishops.

Kezelman, C., & Stavropoulos, P. (2012). *The last frontier: Practice guidelines for treatment of complex trauma and trauma informed care and service delivery.* Kirribilli, Vic: Adults Surviving Child Abuse (ASCA).

Kia-Keating, M., Grossman, F. K., Sorsoli, M., & Epstein, M. (2004). Containing and resisting masculinity: Narratives of renegotiation among resilient male survivors of childhood sexual abuse. *Psychology of Men and Masculinity*, *6*(3), 169-185.

Little, E. (2015). Forward. In National Association of Services Against Sexual Violence, *Standards of practice manual for services against sexual violence.* Hobart, Tas: National Association of Services Against Sexual Violence.

O'Leary., P. J. (1999). Liberation from self-blame. In Dulwich Centre (Eds), *Extending narrative therapy* (pp. 159-189). Adelaide, SA: Dulwich Centre Publications.

O'Leary., P. J. (2001). Working with males who have experienced childhood sexual abuse. In B. Pease & P. Camilleri (Eds), *Working with men in the human services* (pp. 80-89). Crows Nest, NSW: Allen & Unwin.

O'Leary., P. J., & Barber, J. (2008). Gender differences in silencing following childhood sexual abuse. *Journal of Child Sexual Abuse*, *17*(2) 133-143.

O'Leary., P.J., & Gould, (2009). Men who were sexually abused in childhood and subsequent suicidal ideation: Community comparison, explanations and practice implications. *British Journal of Social Work*, *39*, 950-968.

Ogden, P., Minton, K., Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy.* New York, NY: W. W. Norton & Company.

Olgoff, J., Cutajar, M. C., Mann, E., & Mullen, P. (2012). *Child sexual abuse and subsequent offending and victimisation: A 45 year follow-up study* (Trends and Issues in Crime and Criminal Justice No 440). Canberra: Australian Institute of Criminology.

Romano, E., & De Luca, R. V. (2001). Male sexual abuse: A review of effects, abuse characteristics, and links with later psychological functioning. *Aggression and Violent Behavior, 6*(1), 55-78.

Ross, C., & Helpern, N. (2009). *Trauma model therapy: A treatment approach for trauma, dissociation and complex comorbidity.* Richardson, TX: Manitou Communications.

SAMSSA (Service Assisting Male Survivors of Sexual Assault). (2014). *Men surviving sexual assault: A booklet for men who have experienced sexual assault and their supporters.* Canberra, ACT: Canberra Rape Crisis Centre.

Tarczon, C., & Quadara, A. (2012). *The nature and extent of sexual assault and abuse in Australia* (ACSSA Resource Sheet December 2012). Melbourne: Australian Centre for the Study of Sexual Assault.

Trask, E. V., Walsh. K., & Dilillo (2011). Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *Aggression and Violent Behavior*, *16*(1), 6-19.

Van der Kolk, B. A. (2001). The assessment and treatment of complex PTSD. In R. Yehuda (Ed), *Traumatic stress*. Arlington, VA: American Psychiatric Press.