



Submission from the Victorian CASA Forum  
to  
Royal Commission into Institutional  
Responses to Child Sexual Abuse

Issues Paper 10  
Advocacy and Support and Therapeutic  
Treatment Services

November 30 2015

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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The Victorian CASA Forum (CASA Forum) represents the Victorian Centres Against Sexual Assault, which includes the following CASAs:

<b>No</b>	<b>CASA</b>	<b>Governance</b>	<b>Region</b>
1	Ballarat CASA	Program of Ballarat Health Services	Ballarat and Central Highland
2	Barwon CASA	Stand alone NGO	Barwon & Wimmera regions
3	CASA House	Department of Royal Women's Hospital	Melbourne, parts of Western and Inner Northern Melbourne
4	Centre Against Violence	Stand alone NGO	North East Victoria
5	Eastern CASA	Department of Maroondah Health	Eastern Metropolitan Melbourne
6	Gatehouse Centre	Department of Royal Children's Hospital	Melbourne, Western Melbourne, some Statewide Services
7	Gippsland CASA	Stand alone NGO	Gippsland
8	Goulburn Valley CASA	Department of Goulburn Valley Health	Goulburn Valley
9	Loddon Campaspe CASA	Department of Bendigo Health	Bendigo / Central Victoria
10	Mallee Sexual Assault Unit	Stand alone NGO	Mallee – North Western Victoria
11	Northern CASA	Department of Austin Health	Northern Metropolitan Melbourne
12	South Eastern CASA	Department of Monash Health	South East Metropolitan Melbourne
13	South Western CASA	Department of South West Healthcare	South Western Victoria
14	Victorian Sexual Assault Crisis Line	Department of Women's Hospital	Statewide after hours service
15	West CASA	Stand alone NGO	Western metropolitan Melbourne

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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### Introduction

The 14 Victorian Centres Against Sexual Assault (CASAs), together with the Victorian Sexual Assault Crisis Line (SACL), are funded by the state government<sup>1</sup> to deliver a range of support services to women, men (and all people regardless of their gender identity), children and young people who have experienced recent or past sexual assault, including:

- provision of 24 hour crisis care support, across the state, to people who have experienced a recent sexual assault (within the previous 2 weeks)
- short, medium and longer term counselling
- 24 hour telephone support service for clients of CASA and for anyone experiencing distress related to sexual assault
- advocacy
- community education
- professional training and education
- prevention work
- prevention and education work in schools aimed at raising awareness, bringing about cultural change and preventing sexual violence
- secondary consultation with health and community workers

Through an innovative model developed several years ago and being progressively rolled out across Victoria, collaborative arrangements between Victoria Police, local CASAs, the Victorian Institute of Forensic Medicine and the DHHS Child Protection team ensure a coordinated response to recent assaults. This model has been formalised, funded and delivered at Multi Disciplinary Centres (MDCs) now operating successfully in a number of regions.

This submission has been prepared by the Victorian CASA Forum with input from managers and counselling and project staff of the 14 CASAs and SACL, drawing upon over 30 years of experience working with people who have experienced sexual assault and who have lived with the impacts of sexual assault. Our process over the past month has been collaborative and consultative. We have consulted with clients directly but, unfortunately, do not have any direct input from current clients.

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<sup>1</sup> Department of Health and Human Services

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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### Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?
  2. What does not work or can make things worse or be harmful for victims and survivors? What do victims and survivors need but not receive?
  3. What helps or facilitates access so victims and survivors receive what they need? What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?
  4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors? How could these services be shaped so they better respond to secondary victims?
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The Victorian CASAs have been operating for over 30 years. Supported by a model which incorporates a feminist framework and Victims' Rights Model, the CASAs operate from what could be described as a 5 pillar foundation for practice:

1. Trauma informed
2. Gender informed
3. Justice overview
4. Evidence informed
5. Client focussed and Practice informed

The CASAs provide support services to people who have experienced sexual assault and, in addition to the frameworks and foundational aspects listed above, have a strong commitment to social justice. CASA Forum recognises that many of our clients are drawn from the more vulnerable sections of society, including:

- people with cognitive disabilities
- people with physical disabilities
- people who have a history of mental illness
- Aboriginal and Torres Strait Islanders
- refugees and immigrants
- individuals from some migrant groups
- young people and adults with a background in residential care
- children and young people currently living in out of home care

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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All of these groups of people experience higher rates of sexual abuse<sup>1</sup>. With this knowledge, considerable effort is devoted to ensuring our work practices are inclusive, relevant and accessible. For example, CASA Counsellor/Advocates have a sound understanding of the significance of ongoing trust issues for people who have experienced sexual abuse in an institutional setting, including the difficulties this may raise for those people dealing with institutions (such as hospitals, a child's school, Government agencies, police).

### **Advocacy and support that works for clients includes:**

- A specialist service response that is timely, person-centred and respectful.
- An integrated and multidisciplinary response that coordinates support and action in response to individual client need
- Services that are readily available and timely when clients call to access help (rather than long waiting periods), including timely intake appointments for a fuller assessment of needs
- A feminist understanding of the gendered nature of violence<sup>2</sup>
- A systemic perspective of the client's context
- A service response that is informed by both the client's expressed needs and professional assessment which engages the client in the process
- An environment and work practices that are non-discriminatory
- Support letters to schools & work-places to explain absences and/or receive special consideration
- Reports to Victims of Crime Assistance Tribunal (VOCAT) (the Victorian state compensation system for victims of crime) to demonstrate the impact of the crime on a client's life, in order to access funds that may support recovery. CASAs frequently complete these VOCAT reports for clients.
- Court reports that describe the impact of the abuse, the client's commitment to counselling and positive changes in the client's life
- Referral letters and phone calls to ensure the most appropriate support and therapeutic care for clients
- Preparation for a submission to, or attendance at, the Royal Commission
- Letters to NDIS to describe the impact of the abuse on the client in order to inform an assessment regarding capacity to work
- Assistance for clients writing a Victim Impact Statement for Court
- Attendance at care team, case planning and case review meetings

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<sup>2</sup> The use of the term 'feminist' should not be read as 'only concerned with women'. A feminist analysis of sexual assault/abuse highlights how issues of power, control and gender at a social/cultural level contribute to the perpetration of, experience and response to sexual assault/abuse. These are issues of importance for working with all people who have been sexually assaulted/abused.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Secondary consultation/training and consultation to parents, carers, schools & other agencies supporting/working with the client to assist them in understanding and supporting the client
- Case Management. This is identified as a current service gap. Case management offers more intensive support and advocacy to people in relation to housing, financial, health and other system-related difficulties that are beyond the scope of a narrow counselling response.

### **Specifically within the Multi-Disciplinary Centres, advocacy and support of clients by CASA**

#### **Counsellor/Advocates includes:**

- The CASA Counsellor/Advocate taking an overarching and coordinating role in the delivery of crisis care, providing the following:
  - information to the client about DHHS Child Protection, and SOCIT – reports to police in the Barwon area have increased 45% since the inception of the Barwon MDC (Vic Pol Crime Stats)
  - organizing ‘Options Talks’ by SOCIT in relation to legal choices
  - organizing a meeting between a client and Child Protection worker
- The CASA Counsellor/Advocate taking an ongoing role in ensuring the client is supported and kept informed, including:
  - consultation with SOCIT members and/or Child Protection workers in relation to the client’s best interests i.e.: legal updates and progression of Child Protection involvement
  - support of clients and provision of information in relation to legal process
  - linking client with visiting legal service within the MDC
  - Integrated support services that address both family violence and sexual assault

#### **Therapeutic Services that work for clients include:**

- Client led therapeutic approaches, rather than prescribed interventions that are imposed. CASA practice prioritises responsiveness to the client. In their counselling and advocacy work, CASA Counsellor/Advocates are not aiming to diagnose or pathologise. Whilst full assessments are undertaken for all clients, prioritising and ensuring safety and wellbeing, clients are viewed as the experts in their own experience and in setting the pace for the work to deal with the impacts of trauma resulting from the sexual violence they have experienced<sup>ii</sup>
- Maximising client’s capacity to make informed decisions in the therapeutic process. The core dynamic of sexual abuse is the exercise of power to limit the choices and possibilities available to the person being abused. Any therapeutic interaction should endeavour to avoid replicating this dynamic. In some health-related settings, patient compliance with the authority and expertise of the professional is seen as desirable. However, in sexual abuse therapeutic interventions, the notion of patient

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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compliance can replicate the power dynamics of abuse. CASA Counsellor/Advocates are comfortable with being challenged by clients asserting their own expertise about what is of assistance to them, and being as transparent as possible with clients about the reasoning behind any therapeutic intervention that is suggested. Client empowerment is the underlying principle.

- Listening to clients. CASA clients report that this simple principle is extremely significant. Unfortunately, people who have been sexually assaulted/abused report that their experience in mental health settings is all too often one of not being heard.
- Supportive initial phone contact offering clear information and sensitive exploration of needs and/or referral options
- Respect for client confidentiality and transparency about limits (e.g. duty of care, mandatory reporting requirements)
- Short, medium and longer term, face to face counselling for people who have experienced sexual abuse/assault, and/or inclusion of family members and significant others
- Therapeutic support that is available for a sufficient length of time. People who have experienced sexual assault may need access to short, medium and/or long term episodes of counselling at various stages of their life. Individuals also have differing needs in terms of the amount of time needed for trust and safety to develop, in order to enable them to process trauma
- Counselling that recognizes the relational trauma that is experienced when abuse occurs within a family and is open to addressing the needs of the individual and/or family
- Psycho-education addressing questions such as the dynamics and 'causes' of sexual assault<sup>3</sup>, understanding trauma and effects, the neurological relationship between trauma, the brain and body
- An understanding of 'complex trauma' or 'developmental trauma'<sup>4</sup>
- A range of trauma informed therapeutic approaches that support recovery from the effects of sexual assault
- Simultaneously to the importance of trauma informed practice, is the necessity of regarding the whole person in their context, as more than their experience of sexual assault.
- A systemic response to a client's needs i.e.: with client's consent, consultation with other workers who support client

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<sup>3</sup> Clients often come with questions such as 'Why does sexual assault happen? Why did it happen to me? Why did he do it?' While there are often no definitive answers to these questions, Counsellor/Advocates need to be comfortable with engaging in these conversations.

<sup>4</sup> Complex trauma is differentiated from PTSD. PTSD typically refers to responses to a single or contained set of incidents that happen to an adult. Complex trauma acknowledges that when children are subjected to ongoing abuse, this can affect their still developing sense of self in the world (identity). A person's 'blueprint' for relating to others is developed in this context. This is often referred to as 'attachment disorders', and can alternatively be considered adaptive responses to an unsafe environment.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Support groups for people who have experienced sexual abuse/assault that utilise creative modalities that ameliorate the effects of sexual assault. This has included yoga, art making, mindfulness, music therapy, and mandala groups amongst others.
- Group work generally. Clients consistently report the importance and value of groups, where they meet others who have experienced sexual abuse. For some, this is the only forum (outside of counselling, and perhaps their intimate partner relationship) in which they can speak with others about their experiences and impacts related to abuse. In addition to the creative focussed groups listed above, CASAs offer a variety of modalities of group work, including: Trauma-focussed Acceptance and Commitment Therapy groups, psycho-education groups, semi-structured 10 week support groups, facilitator led peer support groups (including support groups specifically for people involved with the Royal Commission process), and monthly drop-in groups. In general, CASA's groups are gender specific. One male client expressed his experience this way (shared here with his permission):

*"It's like a kind of magic that happens when the men come together. It's like a band- 2 people could be really good musicians but sound terrible together. You can't just put any people together and expect it to work. There's something that happens between the group members that I just can't explain- I can only call it magic. People feel better when they come together. We want to hold on to each other. I've never had a brother but I think this might be what it feels like. Brotherhood, a tribe. The deepest respect for each other that I never would have imagined was possible. You heal"*

- While some clients do express interest in mixed gender groups (and this has been offered by some CASAs) in general both women and men express a preference for gender specific groups. An emerging challenge is to meet the needs of people who identify as trans\* and are seeking group support.
- Therapeutic approaches that are framed by the four principles of trauma informed practice: Safety, Emotional regulation, Mourning of Loss and Integration Towards Future
- Therapeutic work that is underpinned by four key principles of trauma informed practice:
  - Safety
  - Emotional Regulation
  - Mourning of Loss
  - Future Focus (Bloom)<sup>5</sup>

### **What does not work or can make things worse or be harmful for victims and survivors?**

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<sup>5</sup> Sanctuary Model, Bloom, Dr Judith L. Sanctuary Web, <http://sanctuaryweb.com/>



# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Pathologising of the person's experience and coping/adaptive responses to the impact of the sexual assault/s. This is frequently experienced by people who have been sexually assaulted, particularly women who enter into the mental health system. It is not uncommon that disclosures of sexual assault/abuse are assessed as delusional symptoms of psychotic illness (e.g. schizophrenia)
- Viewing people who have been sexually abused/assaulted as helpless i.e. workers taking on too much responsibility and not supporting the resourcefulness and empowerment of the client
- Reinforcing societal myths (e.g. victim blaming, the 'victim to perpetrator' myth)
- Presumptions about the person's experience
- Breach of confidentiality
- Disempowerment through the client not having choice or participation in decision-making
- Non-specialist services
  - CASA Counsellor Advocates are qualified and experienced in working specifically with the effects and impact of sexual abuse. Sexual assault counselling is specialised work and CASA staff are supported through ongoing professional development and the provision of regular clinical supervision from senior clinicians who have extensive experience in working with sexual abuse and a sound understanding of vicarious trauma. This framework ensures clients receive the support they need from professional staff.
  - services that do not operate from a trauma, gender and justice informed framework- e.g. services with a focus on relationship mediation or family reconciliation. The therapeutic work of the CASAs is trauma informed, gender informed, evidence and practice informed, client focussed and grounded in a sound understanding of the evidence base that identifies the use of violence as a gendered social issue.
- Adopting a 'one size fits all' approach to counselling without tailoring approach to individual needs. Evidence based practice is useful only to the extent that it is appropriate for the individual client. For example, some treatment approaches that are useful for someone experiencing PTSD following a single traumatic incident, are not necessarily helpful - and may even be harmful - for someone who has experienced ongoing childhood sexual abuse. (Case example: A client accessing NCASA services reported having attended a PTSD treatment group (in a different service) based on an

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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exposure therapy model. This client found the program highly distressing and re-traumatizing, and reported that others had also experienced adverse reactions, in one case loss of control of their bowels while in the group. While exposure therapy can be effective for some people, it must be thoroughly assessed in the light of each person's needs).

- Expectation that the person will re-tell their story of abuse in detail. Without appropriate ground work, addressing safety and stabilisation (Stage 1 trauma work), this can be re-traumatising for some people.
- Conversely to the above, reinforcing silence about abuse by not facilitating a safe therapeutic context that enables people to discuss their experiences (clients feeling they are 'shut down')

### **What do victims and survivors need but may not receive?**

- Justice. Clients often express their disappointment or shock at not receiving an adequate response from police or various parts of the justice system.
- A timely response to receive an appointment and no waiting period for counselling. At present, once a person has made initial contact with a CASA service, waiting times to begin counselling can vary widely. In some cases, due to the high level of demand in particular areas, people can wait up to 3 months before being allocated.
- A trauma informed response. This is often NOT provided when a person seeks support from a non specialist service, such as a generic counselling service.
- A culturally sensitive and gender sensitive response and practice
- Continuity of care. Recent research indicates that people who have experienced ongoing childhood sexual abuse (including those who grew up in residential care) often require ongoing regular counselling, and that this may be required at different stages throughout the person's life. Current arrangements rarely allow for this, particularly where the person cannot afford to pay for private counselling. For example, the Medicare 'Access To Better Mental Health' scheme provides for 10 (partly subsidised) sessions per calendar year, which is simply insufficient for many people dealing with the ongoing difficulties associated with sexual abuse.
- Amongst the most common feedback received from users of our service is that therapy (both individual and group) often comes to an end because of the limits of the service, rather than the needs of the person. While these limits vary across CASA services, with current resources CASAs are often unable to offer long term counselling. As mentioned previously, the support needs – including counselling and advocacy - of people who have experienced childhood sexual abuse, varies from person to person but, frequently, is required at different points in time and, in some cases, lifelong access to counselling is required. The need for counselling and or advocacy might be in

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

terms of developmental stage/s or in response to a trigger such as becoming involved in relationship, becoming pregnant, caring for a small child or experience of a particular challenge or traumatic event.

- Access to a diverse range of therapeutic modalities that assist with recovery from violence, including options outside the traditional one-to-one counselling arrangements (this can be a particular challenge under dominant mental health service funding and provision models). For example, the choice to include family members or significant others in counselling
- For those whose region does not have an MDC, access to a diverse range of trauma informed resources and services (i.e.: health practitioner, Mental Health service, Family Violence Liaison Unit)
- Facility within MDC for people who have been sexually abused/assaulted to give evidence to Court via a remote video link up
- Case management – the support needs of people who have experienced sexual abuse and trauma are frequently complex and multi faceted
- Appropriate avenues for peer support

### **What helps or facilitates access so victims and survivors receive what they need?**

- For recent assaults - a high profile, state wide, specialised, coordinated platform, acting as a 24 hour intake and referral system, incorporating CASAs, police, hospitals and forensic services, such as in Victoria
- In Victoria, appropriate referrals from local agencies which have knowledge of local CASA and the MDC (where applicable).
- Collaborative relationships with other agencies (including GPs, Alcohol and Other Drugs services, Housing services, particularly women's and youth refuges)
- A timely response to request for support/counselling i.e. no waiting period
- A 'seamless' access to other services such as Child Protection, Police Sexual Offences team and legal services
- Services actively seeking and acting on client feedback about their experience of the service and what could be improved
- General community awareness of the problem of sexual abuse, and what support is available. For instance, CASAs have recorded a marked increase in referrals with the high media and community profile of the Royal Commission which has raised public awareness of the issue of sexual abuse.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

**What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?**

- **Barrier 1 Social Attitudes**

- stigma and social attitudes towards people who have been sexually assaulted and to sexual abuse.
- social beliefs which permit and reinforce gender inequality across most areas of society
- pervasive social attitudes about male and female roles, rights and responsibilities, leading victims to believe they may have contributed to, or been to blame for, the assault

Bringing about cultural change and changes to societal attitudes is long term work. The Respectful Relationships programs in schools tackle these issues directly. Feedback from schools indicates there have been some changes in attitude.

- **Barrier 2 non-specialist services providing support**

- services that do not operate from a trauma, gender and justice informed framework - e.g. services with a focus on relationship mediation or family reconciliation. Most particularly, CASA's therapeutic work is grounded in a sound understanding of the evidence base that identifies violence towards women and children – and towards men - as a gendered social issue.
- CASAs frequently hear from clients that they were seeing a counsellor for some months but the sexual assault issues were not adequately addressed, not addressed at all or, in some cases, not ever raised.

Strengthening the links between private and general counselling services, mental health services and specialist services, to enable greater access to secondary consultation with the specialist services (such as CASA), and to encourage appropriate referrals, would begin to address this problem. All CASAs offer secondary consultation and welcome this option where a client has an established relationship of trust with a more culturally appropriate service or worker or with a youth worker or teacher or with a private counsellor.

- **Barrier 3 Service System Model**

- services that operate in 'silos'
- fragmented service systems that are difficult to navigate
- lack of knowledge of specialist service, by other services and health/welfare professionals, due to low profile of specialist service
- extended waiting periods (inadequate funding)
- services that are not resourced to provide family based interventions where required

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- limited range of services, e.g. absence of support groups that offer connection with others who have experienced sexual abuse/assault
- **Barrier 4 Access**
  - no counselling offered in the person's first language
  - no provision of face to face interpreting service
  - potential clients living in rural/remote areas with inadequate means of transport
  - perceived or actual associations with institutions in which abuse occurred (e.g. Church-related, government departments)
  - perceived or actual 'women only' services (or heterosexual, Anglo or English speaking or able bodied services)
  - conversely, services that do not actively attend to safety and risk management for women
  - issues with physical space (e.g. wheelchair access. Can clients enter the building discreetly? This is a particular issue in smaller communities)

Some of these barriers might also be addressed through:

- shared training and networking opportunities
- funding to establish services, extend existing services, resource clients, recruit specialist workers
- funding for professional development of workers (e.g. CASA Workforce Development program ensures workers have access to ongoing training and professional development in areas directly related to sexual assault/abuse)
- strategic promotion of services
- wide distribution of accurate information about service
- liaison and collaboration with other agencies

**How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors? How could these services be shaped so they better respond to secondary victims?**

Generally, 'supporters' (such as non-offending family members, partners, friends- or 'secondary victims') receive limited support and counselling. With adequate or targeted resourcing, services could be more responsive and flexible in offering counselling and assistance for supporters. This would require dedicated funding. In Victoria, all CASAs aim to be responsive to the needs of those seeking support however, due to service demand, have waiting lists for counselling, and those who have directly been sexually abused/assaulted will always be given priority.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

Supporters do benefit from individual session/s for support and may also be included in the counselling with the primary client in order to gain an understanding of the impacts of the abuse/assault, their needs and hopes. In Victoria, through the CASA services, supporters are generally offered a more limited service due to the need to prioritise resources for people who have been directly abused/assaulted,

At the same time, supporters have legitimate service needs of their own and should not be viewed solely in terms of how they might assist the person who directly experienced the abuse/assault.

It is helpful to offer parents/carers of children who have been assaulted 'Child focussed parent work' which assists parents to understand the dynamics of sexual assault, grooming tactics, identifying effects of the trauma and helpful ways of responding to their child. This counselling may also include their child if appropriate. Understanding the experience and needs of parents/carers of children who have been assaulted is critical in assisting them to support their children through their recovery.

### Topic B: Diverse victims and survivors

1. What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups? What types of models and approaches are used to address the particular needs of these populations?
2. How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?
3. What would better help victims and survivors in correctional institutions and upon release?

1. *What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups? What types of models and approaches are used to address the particular needs of these populations?*

Multicultural organisations such as Multi Cultural Women's Health and In Touch provide support and advocacy. However, these services do not always employ trauma specialists. ASRC (Asylum Seeker Resource Centre) addresses the broad range of trauma experienced by its client group. CASAs aim to work in partnership with these organisations to meet the needs of their client group, recognising the importance of both trauma-informed and culturally-informed practice.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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Many Aboriginal health organisations such as Aboriginal Community Controlled Health services have very strong community links and work closely with their local sexual assault and family violence services/counsellors, ensuring access is maintained for members of the community. For example, in Victoria, this is the case in the following areas:

- Gippsland (Gippsland CASA, Yoowinna Wurnalung Healing Centre, which is a program of Gippsland Lakes Community Health Service, and GEGAC)
- Northern Metropolitan Melbourne (NCASA, VAHS & VACCHO)
- Northeast Victoria (Centre Against Violence (UMCASA) and Mungabareena Aboriginal Corporation.
- Badjurr-Bulok-Wilam Aboriginal Women's Support services for people accessing care at RWH (Royal Women's Hospital), work closely with Social Work services at RWH, CASA House and SACL services.
- Eastern metropolitan Melbourne where ECASA has relationships with the Eastern Health Aboriginal and Boorndawan Willam Aboriginal Healing Service and has a counsellor/advocate who regularly sees students at Worawa College in Healesville.
- Barwon CASA and Wathaurong Aboriginal Cooperative - 2 days a week co-located Barwon CASA outreach service, co-located with Wathaurong and providing trauma informed Yarning Circles with Aboriginal practitioners

CASA counselling and advocacy services are aimed at ensuring accessibility for all people and CASAs have numerous strategies & programs targetting particular groups. Examples include:

- Individual counselling and groups provided by all the CASAs
- Training delivered to managers and staff of Supported Residential Services, for people with cognitive disabilities, resulting in increased reporting / referrals from staff of Community Residential Units/ Group Homes and Supported Residential Services
- Men's groups – a number of CASAs run therapeutic support groups for men (8-10 weeks), and/or ongoing Men's support groups
- Young Women's Groups - all CASAs run young therapeutic support groups for young women
- Consumer involvement in the development of resources eg. employment of a local Aboriginal artist to illustrate information booklet for Aboriginal men, and consultation with Aboriginal men's health workers in the development of this resource; focus group with young women clients of CASA in the development of a resource booklet for young women
- LGBTI project with Barwon CASA and the local Government of Geelong – Gay Adolescent Sexuality Project (GASP)
- CASAs undertake outreach to various institutions, to provide therapeutic and advocacy services, for example:
  - aged care facilities

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- correctional facilities , e.g. Dame Phyllis Frost Women's Prison, Thomas Embling Hospital (secure correctional mental health hospital)
- DHHS residential services, including Secure Welfare services
- CASAs also participate in peer education projects with clients with a disability and their service provider. Several CASAs provide Respectful Relationships programs in Special Schools (for students with disabilities).

There is also scope for services being responsive to these communities by considering the nature of services being offered. Individual counselling, for example, is a highly cultural specific practice that is not necessarily relevant or familiar for many people from diverse cultural backgrounds. Thus, in addition to making services accessible for those who want to access them, it is also incumbent upon services to interrogate the relevance of their models of working for local communities.

*2- How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?*

- recognition of the specificity of culture, history and needs of particular communities.
- specific funding for specialist sexual assault services to support new and emerging communities to ensure access to sexual assault support services. Funding should be aimed at supporting partnership work between specialist services and those communities through a community development model which utilises culturally appropriate strategies (e.g. employment of community members and or staff who are fluent in the community language).
- establishment of accessible, specialist services such as the Victorian CASAs, which have a sound understanding of the impact of sexual assault, childhood sexual abuse and expertise in the therapeutic work, to support people affected by sexual assault and complex trauma.

It is important that public funding of programs recognizes the intensive and long term nature of working with particularly affected communities: e.g. communities with a large population of people who arrived as refugees or asylum seekers, Aboriginal and Torres Strait Islander communities, people with disabilities including those living in residential care settings and people with a profound cognitive disability, young people living in residential care and young adults having recently left a residential care situation. All of these groups have significantly high numbers of people with histories of multiple traumas. It is common for people to present at support services in crisis, with immediate safety or basic needs (housing, food, urgent health issues). In addition to the day-to-day impacts of PTSD and complex trauma, there is often a complex picture in the familial, social and emotional aspects of their lives (including, significantly, poverty). Many have mental health issues and severe and long term mental illness.



# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

Funding for support groups at CASAs in partnership with other specific services, specifically designed for people who have gone through the Royal Commission process, to provide an ongoing platform for support, reconnection and restoration afterwards.

Other particular groups whose needs are not currently being adequately met include:

- gay men who have experienced sexual assault or have a history of childhood sexual assault
- certain individuals/ groups with severe mental illness
- young men (adolescent/early adult) are particularly under-represented as service users
- trans\* people (who do not identify as either male or female)
- people who have been sexually abused who have also perpetrated violence, including:
  - people with a history of sexual offending
  - people (mainly men) who have a history of violent or offending behaviours e.g. family violence, use of physical violence

Other suggestions include:

- Trauma and gender informed clinicians within mental health services to promote a greater understanding of the impact of sexual assault within the mental health services
- Increased funding to allow specialist sexual assault services to outreach to mental health services
- Increased information / training re therapeutic approaches that work with clients with cognitive impairment

*3- What would better help victims and survivors in correctional institutions and upon release?*

- The provision of specialist trauma sensitive therapeutic counselling with a gender analysis that is not focused on their offending behaviour but on the underlying experiences of violence and misuse of power perpetrated against them. Shaming people does not facilitate change but giving people an understanding of the connection between childhood trauma and their offending can shed light on the offending. Also being able to provide strategies to assist in managing themselves while in prison and beyond. Two CASAs provide this service in two women's prisons in Victoria. There is not a service like this in prisons for men.
- Information about the impact of trauma and the availability of support services in the community upon release. Assisting men and women to connect with a CASA in the area they are returning to.
- Victorian CASAs will not provide sexual assault support services, except for crisis response to a recent assault, to anyone who has a record of sexual offending behaviours or who discloses violent

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

sexual behaviours as an adult. There is a need to identify forensic counselling services and private providers that hold a gender analysis and trauma model to respond to this particular group of mostly men but some women.

- CASAs provide limited or no service to men in prisons and this is a huge gap. There are regular requests for service but no funds to provide a sexual assault counselling service. There are some issues for service delivery where a victim also has a history or conviction for sexual offending CASAs would not see the man. This is also true for women who are in prison for sexual offending.
- Training for prison officers and other corrections staff about the connections between sexual assault, complex trauma, the brain and offending and 'difficult' behaviour. Prison staff need to be supported to understand the relationship between sexual assault and offending to develop a more empathic response to prisoners.
- Training for prison officers and other corrections staff about the impacts of vicarious trauma and how to manage that with support in the workplace and self-care.

Two WestCASA Counsellor/Advocates have been attending Dame Phyllis Frost Centre, the medium to high security women's prison in Melbourne, weekly for the past eight years. A Loddon Campaspe Counsellor/Advocate has been attending the low security women's prison at Tarrengower for the same amount of time.

When WestCASA initially began work in Dame Phyllis Frost Centre, we wondered how women would engage with the service and how safe they might feel, given that prison is often a very unsafe environment. WestCASA has been surprised at the number of women who have engaged with the counselling and support service and that they have been able to do a significant piece of therapeutic work.

### When clients are inside the prison

When clients are inside the prison, the potential problems accessing the outreach sexual assault counselling are:

- Not being aware of the CASA counselling services. Communication with prison officers and support services is important so that there is information given to women and referrals are made.
- In prison, the women's movements are closely monitored. Every time a client attends any service it can become public knowledge amongst 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

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

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 prison's, being identified as a victim of sexual assault can increase risk of further assault,

- Safety is one of the most important aspects of sexual assault counselling. Without safety in the counselling relationship and counselling space, working through the impacts of sexual assault will not be achieved. Given the limitations around confidentiality and privacy within the prison environment, client safety is hindered. To increase the sense of safety and confidentiality, WestCASA, as far as possible provides a service that parallels our community based service. Where we are physically located in the prison at the end of a corridor is important as all doors have windows and as there is no passing traffic there is less likely to be prison officers or others peering into the room during a counselling session. Strategies have been developed to ensure information is not shared without authority and client files cannot be accessed by other services. WestCASA staff are aware of not participating in enculturated behaviour such as speaking openly (and often negatively) about prisoners in meeting, corridors or lunch rooms. Not leaving client files stored in the prison is a simple strategy that is reported to make some of prisoners feel that their privacy is respected.
- West CASA Counsellor/Advocates work from a Three Phase Trauma Treatment Model as outlined by Judith Herman in her 1992 book Trauma and Recovery:
  1. Safety & Stabilisation
  2. Processing the trauma material
  3. Re-connecting & integration.

As the prison environment in itself is essentially an unsafe space emotionally, psychologically and physically (which for men in prison includes high rates of sexual assault), Counsellor/Advocates work predominately in the first phase of trauma model – safety and stabilisation – which involves grounding work, psycho-education around impact of trauma and resourcing the client to increase their affect regulation (see case studies)

### When clients are released from the prison system

When clients are released from prison, many women indicate that they want to continue counselling in their community but getting help from CASA can be hampered or delayed due to women not having practical support upon release of prison. In Victoria there are two different ways of releasing clients from the prison system.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

Straight Release: Prisoners have an end release date which means that they have served their full sentence. Upon their release, they are not supported to keep up services/programs as they would if they were on a Community Corrections Order (CCO). They are not allocated the time and support within the corrections system to link them into services on the outside. This can have an overwhelming effect on people exiting prison and attempting to adjust back into 'regular' life. There is no support for them in housing, employment, study, daily living support, and financial issues and so on.

Release under Parole - CCO: This client group has slightly more structure and support provided upon their release. In the lead up to their release date, prisoners will be linked with certain services (e.g. housing, financial counselling, employment, drug and alcohol, etc.) however, while they get some intensive support while being incarcerated, once they are released they are instructed to follow through on certain programs, such as drug and alcohol counselling, but they are required to follow up themselves on this.

This then means that in both circumstances (straight release or CCO) sexual assault counselling becomes less of a priority because the elevated stress of finding stable accommodation, employment, financial security and safety in general takes precedence. We know that when a person's basic needs are not met, seeking to continue sexual assault counselling will not be a priority.

Situations where someone who has been in prison also has a child who has experienced sexual abuse and may be receiving treatment at a CASA present further complexity. Firstly, their child's treatment has occurred without their involvement, given their incarceration. There are no structures in place that might facilitate any engagement of the parent in the child's work to assist the child in communicating his/her experience to the parent. Nor are there structures in place to facilitate reconnection between the child and parent post the parent's release. Whether or not the child returns to the parent's care, unless there are orders prohibiting contact with the child, contact between parent and child should be framed in understanding of the child's experience and the point at which they may be in their therapy. Support for parents to be able to engage in the child's therapy and/or gain an understanding of their child's experience so as to support their ongoing relationship is critical for children recovering from sexual abuse. Without designated structures and identified pathways for communicating with and engaging parents both while they are in prison and post release, the opportunities to provide this support are compromised at best.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

### Topic C: Geographic considerations

1-What challenges do service providers face when trying to respond to the needs of victims and survivors outside metropolitan areas (e.g. those living in regional, rural or remote areas)?

2- What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?

*1-What challenges do service providers face when trying to respond to the needs of victims and survivors outside metropolitan areas (e.g. those living in regional, rural or remote areas)?*

One of the main challenges is the added cost in providing Outreach services to outlying areas. This includes both budgetary implications and time spent in travel. There is little public transport in rural regions and, in some areas no public transport, so the onus is on the agency to provide the transport or the funds to access transport. This can be significant and needs to be added into the cost of delivering the service.

Availability and cost of hiring appropriate venues can also be an issue. Outreach Posts can only provide services one day per week which means there is limited flexibility in offering appointments and an inability to attend in a crisis. Ballarat CASA cites one instance where the local Catholic Diocese provides funds for one client who lives in an isolated rural area to attend the CASA service. However, there is no consistency in this provision for clients. It is also difficult to resource a support person for clients who attend Melbourne for a Royal Commission submission hearing which can be a very stressful experience for the client, made worse by the added burden of travel.

Major rural towns are encompassed by smaller areas that have no transport, ie bus service, taxi. Only a few of these areas may have a bus link that will be utilised for delivery of mail and some transport for people with restrictions

- Bus may not make same day return trip
- Travel return can be over 4 hours
- People may have to wait over 8 hours for return trip
- Busses may only operate during school terms in rural communities

Perpetrators of family and sexual violence are known to isolate their partners and children, to limit their movements and their access to friends and community resources. This control is much easier to maintain in a geographically isolated area. Women and children of family and sexual violence often have to rely solely on the offender for transport which seriously inhibits access to services. Monitoring of movements and restrictions imposed and enforced by the offender on movements and travel are commonly seen in cases of family violence. This not only excludes the person from seeking assistance from business hours services but access to After Hour emergency and medical services.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

In rural Victoria, CASAs establish outposts in smaller towns, however, people who have experienced sexual assault often fear accessing services in smaller towns due to being recognised or for fear of breach of privacy and/or confidentiality due to such factors as:

- a sole medical practitioner means that he/she is the family GP
- staff of services may also be neighbours or reside in the local town
- police officer lives and resides in local town and may associate with offender in community activities ie sporting clubs; service clubs

Factors adding to the difficult of service access and provision include:

- geographic isolation / rural and remote areas across the region
- lack of public transport
- transient population
- lack of affordable housing / including public housing
- cross border issues / multiple jurisdictions / criminal justice responses difference between the States and Territories
- high Indigenous populations
- increase in refugee communities within rural/regional areas
- lack of interpreting services in rural areas
- immigrant community members without the same rights or economic and social supports. At present in Australia the status of a migrant person's citizenship has significant implications for the range of supports and services they have access to
- limited or no public transport access requires clients to rely on the CASA worker to have capacity to attend the town. Provision of travel assistance is only valid for those clients who own or have access to a vehicle and or are old enough to have a licence.
- Some clients do prefer the option of accessing sexual assault counselling outside of their local area due to confidentiality concerns. Rural and remote community brings with it an added layer of sensitivity regarding confidentiality and anonymity. e.g. The CASA worker might outreach to the local community health centre where the receptionist is known to the client.
- Time offline travelling. e.g. counsellor advocate will travel up to 2 hours to an outreach site, a huge resource for one appointment. Total of 5 hours for one client appointment. While this may be unusual it is not uncommon for 1 person to cancel and for a counsellor advocate to make a long, all day trip and only end up seeing two clients
- Density of relationships in rural communities are a barrier to clients when they disclose. Specifically, the local police may not believe them, local community members may not believe them, and/or the perpetrator may be regarded as a 'good person' and very well known.

Recruitment and retention of qualified staff is difficult due to the isolation that rural living can impose for qualified and experienced staff. This can be due to:

- Lack of ongoing training facilities
  - No higher education facilities;

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Universities only offer limited or no higher study degrees etc,
- Having to travel great distances for further training and education
- No local primary or secondary education facilities for families
- Higher cost of living expenses
  - Higher costs for food, petrol
  - Return travel trip can be approx 4 hours for services, general living items i.e. food, clothing etc.

*2- What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?*

- Resourcing for provision of group work and associated costs, such as travel
  - Group work provides an opportunity for linking up isolated people. It helps to break down the sense of shame and self blame associated with sexual assault when clients are able to meet with other people who have experienced similar assaults. It widens their network of support. One funded point of contact requires less funding and staffing resources than multiple contacts.
- Access to high quality and useful information online
  - The use of online and mobile technology (e.g. apps) to assist with dealing with anxiety, flashbacks and other trauma symptoms is a growing area.
  - SECASA has developed a reporting app, so that people who have experienced a recent assault can make a report to police.
- Technology and access to technology for the delivery of counselling / advocacy services. Centre Against Violence (northeast Victorian CASA) is prepared to offer Skype counselling and has worked in partnership with CASA Forum to prepare policy and practice guidelines which include instructions clients can use to ensure the work is secure and safe. One issue identified is that reliable internet services are less likely to be available in more rural/remote settings. For example, just 20 k out of Wangaratta does not have access to broadband and if satellite etc is used to gain access the costs are about 3 times the cost of such services in townships. This also requires financial support to access appropriate technology where needed.
- Witness evidence facilities within the Multi-Disciplinary Centres.
- Access to legal information / representation in relation to family court / children's court matters.
- Scholarships for the professional development of rural staff to subsidise fees and travel

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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### Topic D: Service system issues

1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?
2. Given the range of services victims and survivors might need and use, what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need? What type of service models help victims and survivors to receive the support they need?
3. How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?

*1-There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?*

Terminology preferred and used by the Victorian CASA Forum includes:

**Counsellor Advocates** – all the CASAs recruit and employ Counsellor Advocates (C/As). As per the CASA Forum Standards of Practice, all CASA C/As have appropriate qualifications to enable them to work effectively and safely with people who have been severely impacted by trauma. This includes academic training in Social Work, Psychology or equivalent and post graduate training in a diverse range of therapeutic models such as trauma therapy, Family Therapy, Narrative Therapy, Gestalt Therapy, Art Therapy, Sandplay Therapy – and a range of other specialisations. The term “Counsellor Advocate” clearly identifies the importance of the advocacy role in working effectively to support people affected by sexual abuse and social justice aspect of the work.

**People who have experienced sexual/abuse assault** - CASA Forum prefers a descriptive phrase such as this to other commonly used terms such as victims or survivors or victim/survivors. Historically, Victorian CASAs used the term ‘victim/ survivors’, with the intention of recognising both the criminal nature of sexual abuse/assault, and the person’s capacity to survive. In recent years, it has become accepted that this term risks objectifying the person by defining their identity in reference to a crime (or crimes) committed against them. Such ‘identity prescriptions’ are generally considered unhelpful and can promote a view of such



# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

persons as being fundamentally 'damaged'. This is summed by a postcard produced by the Queensland service Living Well, containing the slogan "Sexual abuse is something that happened to me, It is not who I am".

The term "client" is often used to refer to someone accessing a service. .

### **Advocacy and support**

***Advocacy and support** is acting alongside, or on behalf of, victims and survivors of child sexual abuse to support their rights and interests while providing tangible and practical support. This can include helping to navigate and receive support from a range of service systems, such as housing, health and Centrelink systems. Importantly, advocacy and support also often has an element of emotional support to help reduce isolation and build connections and trusted relationships to help with healing and recovery. Advocacy is often provided for individuals. We also include systemic advocacy, advocating for changes to the systems designed to prevent and respond to child sexual abuse, including advocating for changes to services so victims' and survivors' needs are met. (from the Royal Commission's Issues Paper 10 Introduction)*

CASA forum agrees with this way of describing advocacy and support for individuals. Examples of the types of advocacy provided for individual CASA clients includes:

- Advocating on behalf of a client to police, hospitals, VIFM/ VFPMS in relation to a response to a report of sexual assault
- If there was a poor response to a person who reported an assault, the CASA manager will contact the Senior Police Officer at the particular station and outline the problem, as seen by the client and the CASA, and open up a discussion about how things might have been done differently, see if any further follow up can happen now and possibly secure an apology from the people concerned.
- If there had been a poor response by a hospital, CASA would contact the Nurse Unit Manger or Senior Medical Officer in the Emergency Department (ED) and have a discussion, outlining the issues of concern and perhaps suggesting the CASA counsellor/advocate could come in and provide a training session for the medical staff or nursing staff or ED staff on the processes and protocols for responding to a disclosure of sexual assault. In some cases, we have gone on to assist the hospital with developing protocols and established an ongoing working relationships, providing training on an annual basis.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

- Letters are frequently written for CASA clients to schools, universities, workplaces explaining that the person may need to be allowed time out or may need a quiet room if they become distressed, or supporting an application for special consideration.
- CASA C/As often facilitate referrals to other agencies such as housing, child protection, private counsellors or psychiatrists, GPs and community mental health services. This may include speaking directly to workers and advocating strongly for the needs of the client (with the client's permission)

### **Systemic Advocacy**

CASA Forum devotes considerable time to systemic advocacy to address key sexual assault related issues. Over the past 5 years, this has included:

- **Local Advocacy**

Advocacy undertaken by all CASAs to promote local awareness of sexual assault/ sexual abuse issues and inform developments in relevant committees and program areas such as:

- Family Violence
- regional networks aimed at the prevention of violence against women
- Indigenous Family Violence Regional Action Groups
- Children's services – including health, welfare, education, etc.

- **Advocacy with Police**

Working closely with Victoria Police through collaboration and input to, for example, the review of the Police Code of Practice for responding to Sexual Assault.

- **Advocacy with Taxi Drivers**

Advocacy with the Taxi Drivers Association to ensure drivers behave ethically and respectfully towards passengers at all time and to directly address the issue of sexual assault by taxi drivers

- **Victorian Law Reform Commission**

Input to work by the Victorian Law Reform Commission focussed on sexual assault laws and other related areas. This included:

- Prior to 2004, Victorian CASAs and CASA Forum provided considerable input to VLRCs work on Sexual Offences in Victoria.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Development of a submission in response to the Victorian Law Reform Commission's consultation regarding the needs of victims in the criminal trial process

- **Department of Justice**

Supporting the evaluation of the Sexual Assault Reform Strategy by facilitating the collection of feedback from sexual assault victims

- **Victims Support Agency**

Development of protocols regarding supporting people who have been sexually abused during criminal trials

- **Advocacy to address the needs of groups who are particularly vulnerable to sexual assault, including:**

- Liaison with the Office of the Public Advocate and the Department of Health and Human Services in relation to clients with disabilities who have experienced sexually assault and are living in Group Homes or other supported residential settings
- Provision of CASA training to managers and staff of state government Group Homes and other supported residential settings focussed on education about sexual assault, including sexual assault and the law and definitions of sexual assault and how to respond to disclosures of sexual assault by their residents. These training sessions have been offered to agencies in each region in Victoria
- Development of a joint protocol between SRS proprietors, CASAs and the Department of Health - *Responding to allegations of sexual assault in SRS: Clarifying roles for SRS Proprietors, the Department of Health and Centres against Sexual Assault, 2012*

**Therapeutic treatment** includes a range of evidence-informed therapies, programs and interventions for individuals or groups that are provided by trained practitioners, such as psychologists, counsellors, psychiatrists, social workers and other health and mental health practitioners. These services are often provided as part of the health system or funded by government and delivered by the non-government sector (such as is the case with specialist sexual assault services in some jurisdictions) but may also be provided by the private sector. Therapeutic treatment aims to reduce symptoms of ill-health and bring about measurable change in outcomes that improve wellbeing and quality of life. (from the Royal Commission's Issues Paper 10 Introduction)

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

---

This definition generally aligns with the CASA Forum Standards of Practice, however, it is important that service provision around sexual assault is not solely focussed on measurable symptom reduction or indeed, changing the client. We do not begin from the assumption that the client needs to change.

The developments that may occur in a client's life through counselling are not necessarily best represented through techniques of psychological measurement. CASA C/As do not routinely administer testing tools to assess the effectiveness of counselling (individual C/As may use testing where appropriate with clients for a specific purpose). Thus, it may be more accurate to speak of 'describable', rather than 'measurable', change. Looking ahead, it is important that research and evaluation regarding therapeutic interventions prioritise research methods which privilege client's own descriptions of therapy, rather than assuming standardised measures of effectiveness.

To illustrate why sexual assault counselling cannot be viewed solely as a therapeutic issue with the aim of symptom reduction: sexual assault is at core an issue of injustice, and many CASA clients do not ever achieve a sense that the crimes they have been subjected to have been adequately acknowledged (by courts, by police, by institutions, by compensatory bodies, etc). Failure to achieve a sense of justice is not a shortcoming of the client or of the counselling process, yet can fuel intense and justified anger, or feelings of worthlessness or hopelessness, which impact the client's well-being. The best therapeutic response in many cases may be to simply acknowledge with the client the injustice they have suffered. Working with the client to develop ways of incorporating and responding to this sense of injustice in their lives may be a therapeutic goal. However, it is not reasonable to assume the goal is for the client to be less distressed in the face of this lack of justice.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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*3- How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?*

Practitioners who provide advocacy, support and therapeutic treatment for clients who have experienced sexual trauma must be appropriately qualified and experienced. The Victorian CASAs employ staff with tertiary degrees, predominantly in Social Work and Psychology, and many CASA workers have post graduate qualifications in areas such as Trauma, Family Therapy, Systems Theory, Gestalt Therapy or one of the creative therapies such as Art or Music. Recruitment of staff with relevant qualifications and experience is identified and supported in the CASA Forum Standards of Practice. While experience is also important, CASAs ensure staff members are provided with appropriate orientation, supervision and training to ensure their skills are maintained and they are well supported to provide the support services. All Victorian CASAs have a commitment to providing regular individual supervision, usually by senior clinicians.

There is a strong awareness of the impact on staff working in this field of sexual trauma counselling and of the risk and reality of vicarious trauma, which is addressed in a range of different ways, focussed mainly on regular supervision, support and overt monitoring of self care. This is identified and supported through the CASA Forum Standards of Practice.

Access to relevant, up to date professional development is provided across the sector via a Workforce Development program. Dedicated funding is provided for this by the Victorian government Department of Health and Human Services (DHHS) which funds the CASAs through the sexual assault support program in Victoria. Counsellor/advocates are also encouraged to access other appropriate professional development, e.g. workshops run by recognized trauma experts such as Bruce Perry, Rosemary McIndoe, and Janina Fisher.

Providing these services in the context of a staff team where there is peer support is also critical to the wellbeing of counsellors providing sexual trauma counselling.

In addition, CASAs are committed to providing student placements for students completing relevant training such as Social Work or Psychology. This is a means of resourcing more human services workers with the skills and knowledge to provide therapeutic trauma counselling and may enable people from diverse groups to access employment in the area.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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### Topic E: Evidence and promising practices

1. What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional child sexual abuse are emerging from practice-based evidence? Where are these available and who can access them?
  2. What other learnings are emerging from practice-based evidence or from grey literature (i.e. published reports and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?
- Restorative Justice is a practice that CASA Forum is prepared to offer. It is a service option that is located *outside* the legal sector. The services are available at SECASA and the Gatehouse Centre. The service will commence at Centre Against Violence in northeast Victoria in 2016. The Restorative Justice movement is 20-30 years old and has a substantial evidence base to support its work. Its capacity to offer people who have been sexually assaulted/abused an experience of being heard and therefore of experiencing a sense of justice is strong. It also promotes outcomes that enhance recovery. VARJ, Victorian Association of Restorative Justice provide Best Practice Standards, enabling practitioners to work to international standards. Restorative Practices aim to directly involve people affected by harmful acts in healing the practical and emotional harm, and seek to address that harm with healing.  
See: <http://www.varj.asn.au/>. There are a number of conference papers which demonstrate the depth of evaluation of the restorative justice field of practice. Please see the VARJ site and papers such as <http://www.varj.asn.au/Resources/Documents/Int%20Conference%202013%20papers/Using%20Restorative%20Practices%20-%20July13%20-%20Michelle%20Kehoe.pdf>
  - RMIT University recently conducted research investigate the effectiveness of the TACT program (Trauma-focussed Acceptance and Commitment Therapy) with adult sexual assault survivors with PTSD. The results indicated that at post-intervention there was a significant reduction in the participants reported levels of experiential avoidance and a significant increase in the participants' everyday mindfulness, which was maintained at the three month follow up. Additionally the results demonstrated that there was a significant reduction in the participants' trauma symptomatology and general stress at post-intervention, which was also maintained at the three month follow-up.
  - Evaluation of the Women's Health East 'Eastern Media Advocacy Project' demonstrated that training women who had been sexually assaulted or subjected to domestic violence to speak with media

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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about violence against women had beneficial impacts for the women involved, as well as increasing the quality of media coverage of the issue<sup>iii</sup>

- Canine and Equine therapies: therapies that are now emerging that are not reliant on talking in a counselling room and are enabling people who have experienced sexual assault and other forms of trauma to have daily 24/7 support. For example, trained therapy dogs will wake a person experiencing a nightmare and enable them to reduce intrusion. They accompany the person as does a guide dog and will notice and respond to panic/anxiety attacks. Equine therapy is an engaging form of intervention that enables clients to work with themes such as trust and acceptance through an experiential approach.
- Increasing understanding of the neuro-developmental impact of trauma, the use of mindfulness and somatic based therapies and the value of non-language reliant therapies (including creative arts, sand tray and play therapy with children) is continuing to shape therapy for both adult and child victim/survivors of sexual abuse. Further to this, understanding how to work more effectively with the experience of shame and the dual existence of both hope and despair in the lives of victim/survivors, is increasingly shaping service provision.
- Innovative group programs offered by CASAs include:
  - Trauma informed yoga program
  - Art Therapy groups
  - Music Therapy groups
  - Men's support groups – a range of different types of groups have been offered by CASAs responding to the local needs of male survivors, including:
    - therapeutic men's groups
    - ongoing men's groups
    - men's art therapy groups
    - Ballarat men's group model for male survivors of institutional abuse in Ballarat
    - ongoing peer-led groups with CASA workers as the group leaders, or 'consultants' to the peer group.
- Sexually Abusive Behaviours Treatment Services (SABTS)

Since 2007, the Victorian state government has funded a SABTS program throughout Victoria. Nine Victorian CASAs run SABTS, providing therapeutic intervention services to children and young people who display problem sexual behaviours or sexually abusive behaviours. Through the peak body CEASE, SABTS Standards of Practice have been developed for services providing SABTS and these have been reviewed. The CASA Forum Standards of Practice 3<sup>rd</sup> edition, March 2014,

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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refers to the CEASE Standards of Practice. The Standards outline the procedures for CASAs to follow in relation to the provision of services focussed around clients aged 10 -18 years with problem sexual behaviours or sexually abusive behaviours and in respect of clients under Therapeutic Treatment Orders (TTOs) granted by the Children's Court. Driven largely by the CASAs, this work has evolved over the past 10 years, in response to a critical need identified in the community and has been guided by a developing understanding of developmental and trauma based frameworks and their application to children and young people who engage in sexually harmful behaviours. From a limited number of agencies initially providing these services in Victoria, this work has evolved over the past twenty years. Following the changes to the Children, Youth and Families Act 2005 and the funding of additional agencies to undertake SABTs work with the 10-14 age group, 9 CASAs have become involved in the provision of this service.

For further information about SABTS, and the effectiveness of this program, see:

<http://www.secasa.com.au/services/services-for-youth-with-abusive-sexual-behaviours/>

<http://www.secasa.com.au/assets/Documents/SECASA-Aware-5.pdf>

<https://www3.aifs.gov.au/acssa/pubs/workingwith/gatehouse.html>

<http://barwoncasa.org/sexually-abusive-behaviours-treatment-program>

[http://barwoncasa.org/sites/default/files/sexually\\_abusive\\_behaviours\\_treatment\\_service.pdf](http://barwoncasa.org/sites/default/files/sexually_abusive_behaviours_treatment_service.pdf)

<http://www.secasa.com.au/assets/Documents/cease-standards-of-practice.pdf>

[http://www.dhs.vic.gov.au/\\_data/assets/pdf\\_file/0005/589721/adolescents-sexually-abusive-behaviours-families-specialist-practice-resource-2012.pdf](http://www.dhs.vic.gov.au/_data/assets/pdf_file/0005/589721/adolescents-sexually-abusive-behaviours-families-specialist-practice-resource-2012.pdf)

[http://www.dhs.vic.gov.au/\\_data/assets/pdf\\_file/0011/713693/problem-sexual-behaviour-or-sexually-abusive-behaviour.pdf](http://www.dhs.vic.gov.au/_data/assets/pdf_file/0011/713693/problem-sexual-behaviour-or-sexually-abusive-behaviour.pdf)

*3- What evaluations have been conducted on promising and innovative practices? What have the evaluations found?*

- Restorative Justice is connected to LaTrobe University, Law Department and has been evaluated extensively. See the VARJ references above.
- The evidence based for emerging interventions in the context of sexual assault therapy specifically such as yoga, meditation, art and music therapy, EMDR, and Somatic Experiencing Therapy is still developing. Peer reviewed journal articles suggest the above are promising for some clients.
- This relates to an ongoing issue in respect of research funding. As with most human service organisations, CASAs do not receive dedicated funding for rigorous evaluation and research. All CASAs gather feedback from clients through a range of methods including ongoing reflection and



# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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formal reviews at key points throughout the episode of counselling, client surveys and feedback forms. CASA considers the feedback from clients about the services they receive to be an important type of evidence. Responsiveness to requests for particular types of services has been a feature of the work of the Victorian CASAs historically and presently. For example, in response to requests from men who had been involved in the Royal Commission inquiries in Ballarat, the local CASA now facilitates a regular and well attended support group.

- A key point here is that CASAs work is transparent and accountable to clients and funding bodies, we cannot 'wait for the evidence to be published' before responding to the needs of clients. As noted by a recent peer-reviewed article<sup>iv</sup> in the *Journal of Traumatic Stress*, the evidence base for a number promising and emerging interventions in the treatment of PTSD is small and yet to be established (let alone specifically how these interventions might work specifically with people who have been sexually abused). Additionally, there is a substantial and rigorous body of social work literature demonstrating that the demand for 'evidence based practice' is not necessarily in the interests of clients, as it privileges types of intervention which are inherently suited to quantitative evaluations (CBT is often cited as the most 'measurable'). This can overlook the fact that the benefits of some types of therapy approaches are more suited to qualitative evaluations, which 'evidence based' discourses tend to exclude or marginalise.<sup>v</sup>

### Additional comments

#### 1. IMPACTS OF SEXUAL ABUSE

In broad terms, people who have been sexually abused commonly experience the following, to greater or lesser degrees:

- a. Imposed, non-consensual, sexual act/s characterised by coercion, in a relationship or situation of manifestly unequal power, incorporating forceful, or even violent, assault/s on their person. The assault/s results in physical, emotional and physiological responses, both during the attack/s and as an immediate aftermath, and then resulting in long term impacts.

As health professionals, we conceptualise these impacts of sexual assault as trauma and, as CASA clinicians, we view the responses as adaptive survival responses animated in the particular context of the assault/s. This is sometimes diagnosed in clinical settings as Post Traumatic Stress Disorder however, rather than seeing this as a "disorder", CASA clinicians explain this more as complex trauma, particularly in cases of ongoing or longer term childhood sexual abuse in an institution or by a trusted family member or carer.

- b. An undermining of their sense of autonomy; a loss of personal power, leading to often devastating and crippling long term impacts such as low self image, lack of self confidence and, frequently, fear of public places or being alone or any number of situations. Many people who have been sexually abused suffer from chronic anxiety and fear.
- c. A sense of shame

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- d. A sense of responsibility - “I was bad”; “it was my fault”; “I shouldn’t have been drinking”; “I should have resisted more”; I shouldn’t have been dressed like that” and so on.

However, each person has their own unique story and set of circumstances and it is this combination of knowledge about common experience and impacts, in conjunction with the individual story, that are listened to and taken into account by the CASA Counsellor Advocate in their assessment, risk management and provision of support services. Whether an adult victim of repeated sexual abuse as a child, by a family member, or a victim of past or recent institutional abuse or a woman who has had several abusive partners, the impacts are familiar, similar and recognisable as **the impacts of sexual abuse**. Overlaying these impacts are unique, individual impacts – for each and every person who has experienced sexual abuse.

### 2. PUBLIC APOLOGY

Following the *National Apology for Forced Adoptions* by Prime Minister Julia Gillard on 21 March 2013 to people affected by forced adoption or removal policies and practices, CASA Forum observed the significance for many individuals of this apology. This public acknowledgement and recognition, by senior public figures representing public institutions, of the harm experienced by people at the hands of institutions as a result of public policy, went a long way to helping people to heal. We believe lessons can be learned from this. Individual healing may well be supported by a process where current managers of institutions make public statements acknowledging and taking responsibility for the harm caused to individuals through sexual abuse suffered whilst in the care of their organisation at some point in the past. Many clients of institutional abuse say that they want to feel this will never happen to other children.

### 3. PROTECTING VULNERABLE PEOPLE

Another concern of CASA Forum is how to safeguard vulnerable people, such as children and people with disabilities. There is a body of knowledge about the modus operandi of sexual predators/ sex offenders (Police, Criminology research), including the ways they target and groom vulnerable people and where they secure employment to maximise their opportunities to offend. With this knowledge greater consideration might be given by governments to the value, requirements and reviewing of Working With Children and Police Checks and other strategies aimed at protecting vulnerable people.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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### 4. THE ADVANTAGES OF THE VICTORIAN CASA SYSTEM

Advantages, or key aspects, of the Victorian CASA system include that it is:

a. WELL ESTABLISHED

The first Victorian CASA was established in 1975 with regional CASAs being progressively established over the following 20 years. There is an enormous body of specialised knowledge held by the Victorian CASAs.

b. STATE GOVERNMENT FUNDED

Bipartisan, full commitment from all successive Victoria state governments, ensuring a minimum level of ongoing funding which enables forward planning and increases in funding and provision for funding in response to identified new or emerging areas of need. Over the years, the government has been responsive in recognising developments (see below).

c. SUPPORTED BY INFRASTRUCTURE

- Ongoing funding by the state government, across the state
- An annual workforce development program providing specialist training for the CASA workforce
- Built in to the work of all CASAs, and supported by the CASA Forum Standards of Practice, is appropriate care and support for the sexual assault counsellor advocates in response to the Identification of the impact of vicarious trauma – a phenomenon which is well researched and well documented
- Requirement for minimum academic qualifications and relevant experience (for counsellor advocates)
- Sophisticated understanding of the complex nature of the work with victims /survivors of sexual abuse – feminist underpinning, focus on justice, client driven and trauma informed. Requires and ensures the incorporation of a range of therapeutic modalities and interventions, an understanding of the effects of trauma and an understanding of the significance of certain unique aspects such as shame, confidentiality, guilt and the critical need for acknowledgement and advocacy. This understanding is reflected in many different ways, such as the title of “counsellor advocate”, the setup of services, including waiting rooms and counselling spaces and the protocols around the crisis care response.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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d. A STATE WIDE, 24 HOUR SERVICE

e. EMBEDDED IN EXISTING STRUCTURES SUCH AS HOSPITALS AND LOCAL COMMUNITIES

This ensures levels of sound governance and local trust

f. INNOVATIVE AND RESPONSIVE

Supported by the Victorian government's ongoing commitment, CASA Forum and the individual CASAs are continually growing and developing their services and programs in response to community need. From the very early days, when a group of women advocated to provide appropriate support for women who presented at Hospital Emergency Departments, often with male police, to ensure a level of respect privacy and a challenge to the culture of victim-blaming, to a sophisticated, multi layered network of services, with a huge range of programs developed over the years in response to identified needs. These include:

- Specialised Sexual Assault Crisis Care Units in either hospital emergency departments or Multi Disciplinary Centres, and a Crisis Care protocol and response which is followed by hospitals, police, VIFM, VPFMS and CASAs.
- Increased understanding of the needs of men who have experienced sexual assault, which has resulted in targeted services for men and the employment of male counsellor advocates. A number of Victorian CASAs currently having both male and female counsellor advocates, and both male and female clients are offered choice in terms of the gender of their Counsellor/Advocate
- Program responses to the recognition of huge numbers of children and young people displaying problem sexualised behaviours and sexually abusive behaviours, as recognised by Victorian DHHS through their Child Protection unit, by Courts and by the CASAs. This has resulted in a very large, well established SABTS program in Victoria, aimed at assisting these children, the vast majority of whom have been sexually abused
- Program response to sexual abuse of women with disabilities and women, men and children with cognitive and other disabilities
- Program response is currently being developed by the CASAs to clients increasingly asking for opportunities outside of the legal system and the justice options offered by the legal system, to find some level of acknowledgement of the impact of what has happened to them, particularly acknowledgement by the offender or by the institution that employed, supported or harboured the offender. Restorative Justice options are now being explored and trialled in Victoria.

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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- Prevention work by the CASAs. CASAs have been at the forefront of research and development around conceptualising sexual violence and family violence in terms of gendered violence. CASA work aimed at the prevention of sexual abuse and prevention of sexual violence includes:
  - Work in schools: Respectful Relationships programs are run and have been run by CASAs for over 10 years. Most are conducted in secondary schools and some in primary schools.
  - Partnering with state and federal research organisations in the development of papers and submissions
  - Participation in regional working groups aimed at prevention of Family Violence and Violence Against Women focussed on bringing about cultural change in organisations such as local councils, hospitals and educational settings.
  - Community education and training is offered by all the CASAs in their local area. Sessions are run for health, welfare, education and community agencies and workers, focussing on a range of areas including:
    - What is sexual assault? Definitions of sexual assault
    - Sexual assault and the law
    - Responding appropriately to a disclosure of sexual assault
    - Impacts of sexual assault
    - What to do if you suspect sexual abuse
  - Numerous resources have been developed for people who have experienced sexual assault and for parents of children who have been abused and for partners and friends.

## 5. THE FOUNDATIONS OF PRACTICE

The overarching framework of 'trauma informed practice' is gaining traction in mental health services in Australia and internationally. This is in recognition of the fact that many people accessing mental health services have experienced (often multiple) traumatic life events, including child sexual abuse.

While trauma informed care is an important and valuable framework, effective practice for people who have experienced sexual abuse requires service models to consider a number of other factors as well (these might be thought of as pillars of effective practice). CASA services strive to work from the following foundations:

### **Trauma informed**

The 2012 document produced by Adults Surviving Child Abuse Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery (Kezelman C.A. & Stavropoulos

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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P.A.) provides an excellent description of what is involved in providing care from a trauma informed framework.

### **Gender informed**

Trauma experts generally acknowledge the importance of understanding the significance of gender for people's experience of, and recovery from, sexual assault. A gender informed understanding of sexual abuse stresses the ways in which women and men, while facing some similar barriers to disclosure, also face many distinct pressures. Further, research consistently shows that trans\* people are subjected to extremely high rates of sexual violence.

Gender informed practice is essential for working with all people. As sexual assault often creates confusion for people in regards to sexuality, in turn this connects to how people understand themselves as having a gendered identity. As one client of NCASA stated in relation to the significance of addressing gender identity in sexual assault therapy- "That gets fundamentally down to defining who and what you are".

Gender informed practice has grown out of the women's movement which has been integral to establishing current services for all people affected by sexual violence. This has developed from a necessary feminist political analysis of gender and sexual assault, to a nuanced understanding of how social and cultural gender practices can shape people's expectations, limitations, pressures, identity and connections to their community. This framework assists services and counsellor/advocates with understanding, and assisting clients to articulate their experiences of, how gendered dynamics can shape the risk of, experience of, context of, response to, and meanings made of sexual assault.

### **Justice overview**

At its core, sexual abuse is a crime of gross injustice. It is widely recognised that formal criminal legal systems are failing many people who have been sexually abused. CASAs have been at the forefront of advocating for systemic changes to achieve fairer and more just outcomes. Being positioned as an organisation that takes a public position on sexual assault as a social justice issue is an integral feature of CASAs, which differentiates CASAs from more generalist service providers in both the government and non-government sector. For example, in a recent address to the CASA workforce, ex Victoria Police Commissioner Ken Lay publicly acknowledged that CASAs have been instrumental in changing police responses to sexual assault to become more compassionate.

### **Evidence informed**

As discussed elsewhere in the paper, CASAs work from a broad and inclusive evidence model which acknowledges the need for a range of therapeutic responses to our clients. Counsellor/Advocates are

# Victorian CASA Forum Submission: Issues Paper 10

## Advocacy, Support and Therapeutic Treatment Services

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kept up to date with recent development through ongoing training and professional development. CASAs also value highly the feedback we receive from clients about what does, and doesn't, work.

### **Client focussed and Practice informed**

Following from the above, CASAs have always practiced from client focussed and informed model. Counsellor/Advocates do not impose set therapeutic goals, but develop these in collaboration with each client. Assessment of the effectiveness of counselling is ongoing and based on the client's own preferences and therapeutic hopes/aims. At a service level, CASAs respond continually to identified community needs (a prime example being the Ballarat CASA ongoing men's support group for men involved in the Royal Commission Hearings).

### ENDNOTES

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<sup>i</sup> ACSSA Resource Sheet, 2012

Published by the Australian Institute of Family Studies, December 2012, 15 pp., ISBN 978-1-922038-18-0 , ISSN 1838-949X (Online):

<http://www3.aifs.gov.au/acssa/pubs/sheets/rs5/index.html#ap11>

<sup>ii</sup> ACSSA Issues No. 6 December 2006: Services for victim/survivors of sexual assault

Identifying needs, interventions and provision of services in Australia: Jill Astbury:

<http://www3.aifs.gov.au/acssa/pubs/issue/i6.html#introduction>

<sup>iii</sup> Evaluation report available at [http://whe.org.au/wp-](http://whe.org.au/wp-content/uploads/sites/3/2014/10/2014_Resource_EMAP-Evaluation-Report.pdf)

[content/uploads/sites/3/2014/10/2014\\_Resource\\_EMAP-Evaluation-Report.pdf](http://whe.org.au/wp-content/uploads/sites/3/2014/10/2014_Resource_EMAP-Evaluation-Report.pdf)

<sup>iv</sup> Metcalf, O., Varker, T., Forbes D., Phelps, A., Dell, L., Di Battista A., ... O'Donnell, M. (in press).

Efficacy of fifteen emerging interventions for the treatment of post-traumatic stress disorder: A systematic review. *Journal of Traumatic Stress*.

<sup>v</sup> For example, art making with others can contribute to the well-being and connectedness for those who have been sexually assault, as researched in Anne Riggs 2010 PhD thesis based on her work with women at SECASA: The Creative Space: Art and wellbeing in the shadow of trauma, grief and loss, accessible at <https://anneriggsartist.files.wordpress.com/2013/10/anne-riggs-thesis-1.pdf>. This is a good example of the kind of evidence that is valuable, yet not measurable.