



People with Disability Australia Incorporated

Postal Address: PO Box 666
Strawberry Hills NSW 2012
Street Address: Tower 1, Level 10
1 Lawson Square
Redfern NSW 2016

Phone: 02 9370 3100

Toll Free: 1800 422 015

Fax: 02 9318 1372

TTY: 02 9318 2138

Toll Free TTY: 1800 422 016

Email: pwd@pwd.org.au

TIS: 13 14 50

NRS: 1800 555 677

NGO in Special Consultative Status with the
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People with Disability Australia (PWDA)

Royal Commission into Institutional Responses to Child Sexual Abuse Issues Paper 10: Advocacy and Support and Therapeutic Treatment Services

**Submission
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About People with Disability Australia

People with Disability Australia (PWDA) is a leading disability rights, advocacy and representative organisation of and for all people with disability. We are a national, cross-disability peak representative organisation and member of the Australian Cross-disability Alliance. We represent the interests of people with all kinds of disability. We are a non-profit, non-government organisation.

PWDA's primary membership is made up of people with disability and organisations primarily constituted by people with disability. PWDA also has a large associate membership of other individuals and organisations committed to the disability rights movement. We have a vision of a socially just, accessible, and inclusive community, in which the human rights, citizenship, contribution, potential and diversity of all people with disability are recognised, respected and celebrated. PWDA was founded in 1981, the International Year of Disabled Persons, to provide people with disability with a voice of our own.

Our Expertise in this Area

People with Disability Australia has extensive expertise in the area of advocacy and support and therapeutic treatment services. We have been funded as a Royal Commission Community-Based Support Service by the Department of Social Services to provide individual advocacy to people with disability who are affected by the Royal Commission.¹ As part of this process, we have provided advocacy to individuals, connected them with various support and therapeutic treatment services, and provided systemic advocacy related to the situations they have and are continuing to face.

We are also funded under the National Disability Advocacy Program (NDAP) to provide individual advocacy to adults and children with disability more generally, and so have a broad sense of how service systems and individual services are provided to survivors of child sexual abuse. The case studies used in this submission are predominantly stories derived from our individual advocacy work, but also include a number of other examples drawn from other organisations work in this area.

Introduction and Recommendations

PWDA welcomes the opportunity to comment on this Issues Paper. This submission address each of the topics A – E and in doing so canvasses many of the issues that survivors and victims, both children and adults with disability, face in seeking support services, advocacy and/or therapeutic treatment services. There are ten key areas for reform and improvement which are addressed in the following recommendations:

- 1) The array of services required by survivors and victims of child sexual abuse must be recognised and funded, including: income support, education and training, employment services, housing , in-home support, sexuality and relationships training, treatment for problematic sexual behaviours, violence response services, case management, communication supports, legal services, independent individual advocacy, information and advice, systemic advocacy;
- 2) All mainstream advocacy, support and therapeutic treatment services to have the level of disability competence necessary to enable them to recognise disability, to amend service provision to ensure that people with disability can access it, and to provide referrals as appropriate;
- 3) All advocacy, support and therapeutic treatment services, including disability services, to be fully trained in trauma-informed support to enable recognition of the impacts of trauma;
- 4) All advocacy, support and therapeutic treatment services should have good cross-sectoral relationships with, for example, disability advocacy services, disability support services, Aboriginal and Torres Strait Islander health services, and so on, to ensure both an ongoing awareness of the needs of these specific populations, and to facilitate cross-sectoral collaboration in support of clients.

¹ See www.rcsupport.pwd.org.au

- 5) Individual disability advocacy must be fully funded, in accordance with the recommendations made in the recent Senate Inquiry into Violence, Abuse and Neglect of People with Disability;
- 6) Disability systemic advocacy must be adequately funded to a level commensurate with the funding provided to service provider peak bodies;
- 7) The number of highly qualified trauma therapists must be increased;
- 8) The number of therapists using alternative or non-talk-based therapies such as art, narrative, music and play therapy must be increased;
- 9) Evaluation of alternative or non-talk-based therapies such as art, narrative, music and play therapy should be funded and undertaken, with a particular focus on the success of these therapies with people with intellectual disability; and
- 10) Services directed towards secondary victims and collective experiences of trauma, such as community arts and history projects, to be developed, evaluated and funded.

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?

An array of advocacy, support and therapeutic treatment services work for victims and survivors. Indeed, in the majority of circumstances, adequate support for a victim or survivor involves a range of different services. Although the focus is (legitimately) often on psychological supports, this can be to the neglect of other essential services. Our experience of providing advocacy to people with disability affected by the Royal Commission has involved engaging with a variety of services to ensure adequate support for victims and survivors. These include:

Income support – frequently victims and survivors have found that trauma has impacted on their early education, which has in turn negatively affected their employability. They experience high levels of poverty as a result.

Education and training – frequently victims and survivors require further education and training in order to increase their employability.

Employment services – victims and survivors often need support to access employment.

Housing – frequently people impacted by child sexual abuse have found it difficult to maintain housing due to poverty resulting from difficulties with employment, and episodic psychosocial disability which can impact on maintaining tenancies as well as home hygiene.

In-home support – survivors and victims often struggle with basic self-care such as shopping, cooking and cleaning. This kind of support is particularly important during periods of intensive psychosocial disability.

Sexuality and relationships training – many victims and survivors of child sexual abuse experience sexual assault, domestic violence and other forms of abusive relationships in adulthood as well due to the impacts of trauma. Providing training about how to have respectful relationships and a positive sexual life would support healing processes.

Treatment for problematic sexual behaviours – this is important both for children and for adult survivors and victims, as it can assist with addressing problem sexual behaviours that can in some cases result from child sexual assault. The treatment should be non-shaming, and ensure that it is only used when appropriate, i.e., poor referrals are picked up prior to treatment starting.

Violence response services – many violence response services – which include domestic and family violence response services – have a particular set of expertise in responding to the impacts of violence on a person's life. They are uniquely equipped with a good grasp of how to assist in healing, how to ensure ongoing safety, and how to connect with other services. In the majority of circumstances, victims and survivors of child sexual assault will only become eligible for these services if they experience domestic and family violence. Although research shows that victims and survivors are much more likely to experience domestic and family violence, better funding for and access to violence response services for survivors of child sexual assault more generally is likely to improve outcomes in terms of healing.

Case management – many survivors and victims need multiple services, and it can become a disproportionate burden for an individual to manage and coordinate all of them. Case management of a high level – ongoing, person-centred, and pro-active – can assist with ensuring that survivors get access to the right supports. This case management should be robust, and understand the variety of needs survivors may have. In our experience, the case management currently available to Royal Commission clients often lacks a robust understanding of the services required for people with disability.

Communication supports – for many survivors of child sexual abuse, communication may require extra support. This can be because of developmental delays associated with the impacts of trauma, because of pre-existing impairments, or a combination of the two. There are inadequate communication supports available for people with disability, and few mainstream services have any familiarity with them. This can impede general communication, recovery from trauma, and can put people at a heightened risk of repeated violence as well.

Legal services – many survivors and victims need advice and support around legal questions associated with the crimes committed against them. Additionally, they may be facing contemporary legal challenges which have been impacted by their trauma, ranging from the perpetration of crimes, through to employment discrimination, or pursuing criminal or civil cases regarding their abuse.

Individual advocacy, advice and information – many survivors and victims struggle to advocate for themselves, often because child sexual assault has damaged their sense of self-worth. This often means they struggle to argue for what they are entitled to, and may not understand how eligibility criteria work to include them. Additionally, few are aware of what services are available or how to access them. Independent advocacy - which in its best form acts on behalf of a person while supporting them to develop their own advocacy skills - is essential in this space. It can also help services to learn how to flexibly respond to an individual's needs.

Systemic Advocacy – many survivors struggle to access appropriate services, supports and funds to assist them in healing from their trauma. They face numerous impediments and although these are felt individually, they function structurally. Systemic advocacy assists in ensuring that these structural impediments are recognised and addressed in order to improve access.

2. What does not work, or can make things worse, or be harmful for victims and survivors?

What do victims and survivors need but do not receive?

There are many things that are well acknowledged to make things worse or be harmful for victims and survivors. These include: being dismissed, having the violence downplayed, being blamed for the abuse, being told to 'pull your socks up', being told to 'get over it', being told that they must have brought the abuse on themselves, being treated as if the violence against them doesn't matter, being treated as if the impacts of trauma were simple bad behaviour and so on. For an individual to have to justify or prove that the impacts of trauma are legitimate is part of the continuing effects of the injustice of child sexual assault.

In addition, many people are required to have psychological assessments or other forms of 'quantifying' the impacts of abuse on them, especially as a way of proving eligibility for some services. This can leave survivors with the sense that they may be illegitimately accessing supports, or that their access to supports is dependent on continuing to manifest high levels of trauma.

Many survivors or victims may already be accessing services, such as disability services for people with disability, and in some circumstances these services may not respond well to the impacts of trauma. In some cases, people with disability have avoided accessing services because their initial contact was so poor.

Disability support service providers are often very poor at responding well to disclosures. Staff are frequently not trained in how to respond, which can lead to victim-blaming or a failure to believe. In many circumstances, people with disability are expected to continue living with perpetrators due to a lack of alternative affordable and appropriate housing. This can mean that support workers downplay the significance of a history of sexual assault as a child, or that people with disability are

impeded from the healing practice of exploring their sexuality in a supportive environment. Failures within the disability support system can mean that some people with disability may never be supported to access the psychological and other support services they need as a result of their experiences of child sexual assault.

In many circumstances, disability services are extremely poor at responding to trauma, and to the aftermath of child sexual abuse more generally. Trauma impacts are described as “challenging behaviours,” and put down to a person’s disability which can lead to the use of “restrictive practices” such as solitary confinement (“seclusion”) or forced sedation (“chemical restraint”) or being tied up (“physical restraint”). All of these can compound trauma, and leave survivors or victims experiencing even higher levels of vulnerability. The recent Senate Report on Violence, Abuse and Neglect Against People with Disability recommended a ‘zero-tolerance’ approach to the use of ‘restrictive practices’.²

All of these attitudinal barriers combined are barriers to healing and/or recovery, or even to access the services required to begin the long journey towards healing and/or recovery.

Example: A client of our individual advocacy service who experienced sexual assault as a child but not in an institutional setting is regarded by her government disability service agency to exhibit “challenging behaviours.” These have resulted in the provider refusing to take her phone calls, and only taking calls from a family member who is an alleged perpetrator. It has also led to other disability service providers refusing to provide services to her. Due to the failure of the service system to recognise and respond appropriately to the impacts of trauma the client was displaying, and other forms of advocacy not working, as a last resort an advocacy organisation was compelled to request guardianship for her.

Example: A PWDA individual advocacy client was residing in a congregate care facility and also receiving counselling support. The email regarding his counselling support appointment was printed out and stapled to the shared scheduling book, which was in public view in the front of the facility. Because the email explicitly mentioned the Royal Commission, this meant that anyone passing by the book knew that he is a survivor of child sexual abuse, breaching his confidentiality and potentially placing him at risk.

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?

The primary barrier to access is funding: there are simply not enough services provided for survivors and victims of child sexual abuse. In many cases services lack capacity, and so are forced to prioritise. For example, local sexual assault counselling clinics may prioritise recent survivors of sexual assault over those disclosing many years after the event.

Additionally, eligibility requirements – often determined by funding contracts – can make it difficult for survivors to access services. For example, housing and disability support providers may require that a person have a ‘diagnosed disability’ either in order to access, or to ‘move up the queue.’ In

² Community Affairs References Committee (2015) Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability. The Australian Senate.

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Report

many cases, the queue is so long that without a recognised disability, a survivor will never access support.

Victims and survivors need access to a full variety of services to support them, as appropriate for their individual needs. Many survivors and victims need access to multiple services, as outlined above. In many cases, it is difficult for them to manage the coordination of these services, and this can impede their access.

Further, very few mainstream or disability support services have adequate trauma-informed staff. It is especially important that psychological supports and counsellors are properly qualified, with extensive experience in working with post-traumatic stress disorder and other trauma impacts. Additionally, many services do not have staff with adequate training in trauma (including for front-line staff), and in many instances, this leads to survivors with disability being refused access to services. It can also mean that inappropriate comments are made by staff so survivors with disability decline those services in future. For example, a person who is receiving in-home support may have a support worker make a derogatory remark about them needing to just 'get over' their psychosocial disability.

Even rarer are those sexual assault services which are disability competent. In some instances, services refuse service immediately to a person with disability, sometimes assuming that a more appropriate service will be available elsewhere. This is almost never the case.

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

Many services also insist on providing their service with no adjustment or flexibility to respond to the specific needs of a person with disability, such as having shorter counselling sessions for people with intellectual disability, or utilising non-conversation-based psychological therapy for people with limited communication. For non-psychological as well as psychological support services, there is often very limited awareness of alternative or augmentative communication techniques and technologies. This can mean that people with disability are simply excluded from accessing the service. By failing to make reasonable accommodations these services may also be in breach of the Disability Discrimination Act 1992.

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?

It is often difficult for secondary victims and survivors to even be recognised as victims and survivors, let alone access advocacy, support and/or therapeutic treatment services. Indeed, even where secondary victims and survivors are recognised, this recognition is often limited to family members. It is important to highlight that there are other secondary victims and survivors, including institutional staff.

The failure to treat these secondary victims has extensive impacts on primary victims as well: it can impede people from hearing disclosures, responding well, providing appropriate supports to primary victims, referring them to the support services they require, or from ensuring that primary victims are even notified about the existence of the Royal Commission or other formal avenues of complaint.

In addition, there is the referred or collective trauma that may be experienced within, say, a school community or the community surrounding a particular institution. This can have tangible and ongoing impacts on the inclusion and responsiveness of both primary and secondary victims within a community. In turn, this has substantial negative effects on the inclusion of trauma survivors within that community. In relation to people with disability, unresolved collective trauma has impacted on how supportive a community might be of a person seeking to share their story with the Royal Commission. For example, some support workers are anxious about the impact that supporting a person with disability to share their story with the Royal Commission might have for them personally, especially within a workplace or community which has not yet come to terms with the violence that has been experienced.

Example: A significant piece of PWDAs work in support of the Royal Commission has centred upon a large former institution for children in a regional town. This institution had at least 6 perpetrators as staff and as volunteers, and whilst in operation it was probably the second largest employer in the town. It closed in 1990, based solely on scandals related to physical abuse, so there are still numerous stories of sexual abuse which remain concealed. Our work in this regional town has revealed that even now, over thirty years after the closure, there is still substantial trauma experienced not only by ex-employees of the institution, but by their families and friends as well. Indeed, the community as a whole has not recovered. In our experience in this regional town, the lack of supports for secondary victims here has substantial impacts, perhaps most acutely on primary victims. Secondary victims frequently express denial, or downplay the trauma experienced by primary victims, often directly to these victims. In many cases, others in the community hesitate to support primary victims – even to include them fully in their community – because it involves ongoing recollection of a live trauma. Over time, PWDA has had contact with numerous secondary victims, and in many circumstances it is clear that they remain in denial, seek to downplay, experience anger, or otherwise struggle to grapple with the ongoing collective trauma experienced in this town.

In the main, the lack of access to services for secondary victims and survivors is likely to be a consequence of inadequate funding of frontline services for primary victims and survivors. Inflexible eligibility criteria can preclude secondary victims and survivors from accessing services, and an overall lack of services creates a false antagonism or competition between primary and secondary victims and survivors in terms of both access and recognition. This is problematic, especially where secondary victims and survivors are seeking to provide support to primary victims and survivors.

However, this is only true where the primary and secondary victims and survivors are of more or less the same social standing within a community. People with disability struggle to access advocacy, support and/or therapeutic treatment services far more even than those who might be supporting them. Parents of a child victim or survivor with disability, for example, may be more able to access appropriate supports than their child with disability solely because of the limited disability competence amongst support services, advocacy services and psychological support services.

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?

Independent advocacy, advice and information is a key service which caters to the needs of people with disability. In the context of complex and disjointed service systems, and structural inaccessibility, disability advocacy is essential to support people with disability accessing the services they have a right to. Individual advocates provide support with, amongst many other things:

- Attending court

- Attending a police station
- Making a statement
- Applying for public housing
- Accessing disability support services
- Accessing Centrelink
- Accessing disability-related schemes, such as community transport
- Accessing appropriate services from the health, counselling, etc... sectors
- Negotiating with services of various kinds in terms of how they provide services
- Applying for Victims Supports payments
- Facilitating communication with various services, systems and individuals
- Supporting decision-making
- Ensuring that clients remember appointments
- Acting as interface with particular service systems to take the burden from a client
- Accessing guardianship or financial management
- Assisting with the reassessment of guardianship or financial management where a client no longer wishes to access them
- Providing basic emotional support and 'accidental counselling'
- Supporting the development of support networks around an individual
- Advising and assisting case managers
- Supporting individuals in making complaints (through formal and informal processes)

Without these supports, many people with disability who are survivors or victims of sexual abuse are less likely to access relevant services, to heal from trauma, and to develop the kinds of lives that they want to live.

In general, there is inadequate expertise regarding sexual assault counselling and support services for people with disability. Those services which are designed for people with disability, such as in-home support services, often do not understand how trauma impacts manifest, and rarely understand how to respond to trauma. This can mean that trauma impacts, such as aggression, are believed to arise from the person's impairment, and can lead to the withdrawal of services rather than the referral to additional or more appropriate supports.

On the other hand, mainstream services, especially sexual assault and/or trauma counselling and psychological support services, are often inflexible in how they respond to people with disability. Indeed in some cases, there is an assumption that there will be 'specialist' services available for people with disability, when those services most often do not exist (at least in their area).

In general, it should not be assumed that people with disability require alternative, specialist forms of psychological support. For many, many people with disability, the most that will be required is some minor amendments to therapeutic processes: a change to the length of sessions, for example, or to the reliance on written/reading 'homework', a change to the frequency of sessions, a change to the mode of delivery, or a change to the location in which therapy is provided to enable physical access. Unfortunately, many counselling, therapeutic or psychological services do not provide this flexibility.

Example: PWDA received contact from a counselling service who had recently received a referral for a blind client. The counsellor was seeking a 'more appropriate' service for this client. There was a clear assumption that the counselling service would not provide support to a person with disability, despite the impairment having little if any impact on the style and mode of the therapeutic process. Indeed, the client had simply requested that if there was a reliance on written materials, these be made available in braille so that they could read them.

Part of PWDA's Disability Support for the Royal Commission project has involved delivering Disability Competency training to Royal Commission Community Based Support Services. We have received very positive feedback on this training, which should be used as a model for ensuring the accessibility of all therapeutic support services across Australia.

Our experience suggests that local sexual assault counselling clinics across Australia are substantially more flexible in providing services to people with disability than other larger services. In many circumstances, they have experience in assisting people with complex needs, which often makes them more flexible and responsive to the needs of their clients.

There are some people with disability, especially those with compounded trauma, other psychosocial disability and/or cognitive impairment who may require substantially specialist counselling services. To our knowledge, WWILD in Queensland is the only specialist counselling service for people with intellectual disability who have experienced sexual assault. There are other specialists within other services around Australia, but these are very limited in number. We understand there to be only three specialists in this area in Victoria, for example.

Specialist forms of counselling for people with intellectual disability or with communication support needs tend to orient away from the dominant Cognitive Behavioural Therapy, and similar therapeutic forms which focus on talking as the key means of providing therapy. In many cases, these specialist forms of counselling build more on Art Therapy techniques to assist people with disability in working through trauma. However, because the specialists providing these services are so few, and so geographically disparate, the risk of losing key knowledge, practice and experience from the sector as a single worker retires or moves into a different role can be substantial.

To our knowledge, few specialist services have invested substantially in ensuring intersectionality of service provision: that is, it is unclear whether they are equipped to provide culturally competent services to Aboriginal and Torres Strait Islander people, or to people from diverse cultural and linguistic backgrounds. Narrative therapy is often more appropriate in these contexts.

Disability advocacy services are an essential support service, and have the added benefit of progressively ensuring an increase in the accessibility of a variety of individual support services, including counselling, housing, etc... As has been frequently noted, these services are dramatically underfunded and function continually at maximum capacity. In many circumstances, this means that disability advocacy services are unable to support extra demands.

PWDA is the only individual disability advocacy service funded to support people with disability to access the Royal Commission into Institutional Responses to Child Sexual Abuse. The Royal Commission and the Disability Support for the Royal Commission project have received significant and sizeable support from the disability advocacy sector.

However, some advocacy organisations have expressed to us that although they have existing relationships with clients to whom the Royal Commission is relevant, they simply do not have the capacity to support these clients to come forward. In many cases, their capacity has also been impacted by increased demand for advocacy services in relation to the NDIS which has not been matched by increased funding. However, it should also be noted that many advocacy services must 'triage' intake. For PWDA, Royal Commission clients always receive advocacy as a priority. However, for other advocacy organisations, a client experiencing current ongoing abuse is likely to be given priority over a previous client who may have a story to share with the Royal Commission but has not made contact with the advocacy service.

Such clients are only likely to respond positively to an approach from an individual they already know and trust. Many advocacy organisations have long-standing relationships with local support services who support these clients, and are thus more likely to be able to ensure adequate support

– with transport, for example, or with making telephone calls – to ensure the client can in fact access the Royal Commission. However, they may require additional funding in order to do this.

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?

Mainstream services must become disability competent, responding to the needs of each individual client presenting before them. Services must understand the provision of services to people with disability as a core part of their business. They must not assume that there are specialist services which are more appropriate – because in the vast majority of cases, there is not. Disability specialist services must become trauma-informed, especially to avoid the compounding of trauma through ‘restrictive practices’ as a response to ‘challenging behaviours’. There needs to be better coordination of services, collaborations across sector siloes, and better access to disability advocacy.

Many of these factors – better coordination, better training and increased accessibility – require extra funding and less competitive processes for grant/tender. New funding models have involved reductions in funding – such as through withdrawing CPI increases to grants, or requiring competition between services in a tender process – and has led to a loss of expertise, a loss of funding for training or internal innovation, and a loss of the capacity for interagency collaboration. All three of these things are essential to ensuring disability competence of all services, both mainstream and specialist.

In addition, it is important that education supporting the provision of all kinds of services includes training in diverse populations, trauma, and complex needs. In many university programs for psychologists, for example, there is limited if any coverage of the needs of people with intellectual disability, or how to use alternative or augmentative communication devices. If there is coverage, it is often in an elective, meaning that many people miss out. There must also be an ongoing commitment from psychological therapeutic and counselling support services to ensure ongoing disability competence and accessibility.

In relation to disability advocacy, we commend the recent findings of the Senate Inquiry into Violence, Abuse and Neglect Against People with Disability³ in relation to disability advocacy, specifically as included in Recommendation 16:

The committee recommends the National Disability Advocacy Program implement the following recommendations:

Significant investment to National Disability Advocacy Program funded advocates, to deliver equitable access and representation of issues and to match the increased demand for advocacy anticipated under the NDIS;

Undertake a review to ensure delivered advocacy is appropriate spread across service types and complaint types, to ensure the most vulnerable are received advocacy;

Increase funding for self-advocacy program;

Ensure that the current model of funding peak bodies does not inadvertently result in the closure of smaller specialist or local advocacy organisations.

It also provided the following recommendation in relation to counselling and support services:

³ Community Affairs References Committee (2015) Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability.

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Report

The committee recommends all levels of government provide increased funding for support and counselling services. This should be to create specialist disability counselling services where required, as well as to mainstream organisations so they may meet the needs of people with disability.

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

People with disability are considerably overrepresented in correctional institutions. It is estimated that between 65-85% of all current prisoners have some kind of impairment. These estimates are approximate because disability is routinely under-recognised both within the correctional systems, and by police. In many circumstances, people with disability may only receive a diagnosis as they enter prison. Additionally, many are victims and survivors of child sexual abuse.

Yet despite all of this, correctional services only provide disability support services to those within designated 'disability specialist' blocks within prisons, meaning that inmates whose disability is not recognised may not receive relevant services. Additionally, many of the 'normal processes' within prisons are violent and re-traumatising, especially for victims and survivors of child sexual abuse. This can compound existing traumas and increase post-traumatic stress disorder (PTSD).

While some limited counselling is provided to inmates, it is well-recognised that because of the transience of the population within prison, much of this counselling could be better understood as 'mental health first aid.' It rarely includes the breadth of responsiveness, awareness and disability competence required; and disability advocacy is rarely provided to inmates. The unwillingness of therapeutic services provided in prison to 'open a can of worms' unfortunately does often make some sense, especially in terms of protecting inmates from violence within the prison.

Nonetheless, prison could provide better opportunities for inmates who are victims and survivors, especially in:

- Accessing therapy to deal with ongoing trauma from child sexual abuse
- Accessing the right kinds of support for their impairment/s (and learning what they are)
- Accessing education (given many survivors and victims cannot complete high school or further education).

This is often precluded by short sentences and a high level of transience for prison populations. Unfortunately meaning that on release, survivors and victims of child sexual abuse are not in a better situation than when they went into prison. Indeed, in many circumstances they are worse off. Yet they receive very limited services as they leave prison. An intensive package of the services outlined above, including disability advocacy and disability support services, should be developed and made available to inmates well in advance of their release. Transition/release planning should be robust and ensure ongoing case management.

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)?

People in these areas are often already isolated. Accessing services may be very difficult, and in some circumstances there is only one service, which may not be appropriate for a variety of reasons. For some survivors, they may have burnt bridges with a single service provider due to being 'non-compliant' or experiencing a similar failure to recognise trauma. Small towns can lend themselves to a lack of confidentiality which can also impact on people accessing services.

The benefits of phone and/or internet-provided support are extensive, especially for people with disability who may have limited access due to geography, the accessibility of the service itself, or

because they would prefer not to leave their house. However, by the same token, many people with disability, especially those in boarding houses, group homes and other institutions, may have difficulty accessing technology – even just the phone. It may be particularly difficult to have confidential access to a phone or computer.

There can be difficulties with travel: in many regional or remote areas, there is no public transport, forcing people with disability to use taxis, which is frequently very expensive and can deny them confidentiality. Alternatively, they rely on those providing formal and informal supports, which again can be costly.

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

Services of all kinds must be increased, especially in regional and remote areas. A diversity of support services is essential to ensuring that people have a choice of supports. Given that diversity is likely to be limited in regional and remote areas, disability competence is especially important for these services, as people with disability may have nowhere else to turn for support/advocacy/counselling/case management etc...

More extensive use of internet/video conferencing technology in the provision of counselling in particular would be useful. A greater availability of confidential spaces in which public telephone or internet can be accessed. While libraries often currently provide internet access for the public, this is most commonly in open spaces.

Fly-in, fly-out services should be increased. Although this is often expensive and difficult, it can be the only way to access appropriate services, especially for people with disability. Ensuring that services are funded to provide fly-in, fly-out services would assist greatly.

Ensuring that systemic advocacy is provided with the resources to maintain constant contact with regional and remote areas is essential to addressing the tendency of government to orient services around metropolitan areas.

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?

Missing from the definition provided in the Issues Paper is a reference to the legal system and disability services (in the list of service systems that survivors and victims are supported to navigate). Some disability services can be understood as a form of advocacy and support service, it is also important for 'mainstream' advocacy and support services to have a good grasp of how the disability service system functions, so they can help their clients navigate it. This is especially important as many survivors have undiagnosed or poorly diagnosed disability – in some cases psychosocial disability arising from trauma impacts – and advocacy and support services must be equipped to recognise and support these clients.

Additionally, advocacy includes self-advocacy programs, primarily designed for people with intellectual disability, which play an important role in educating them about their rights, about what constitutes violence, and how to prevent it.

Systemic advocacy is important not only for changes to the systems designed to prevent and respond to child sexual abuse, but also for changes to those systems which put children at risk. For

example, PWDA engages in a significant amount of advocacy around schools, institutions and disability services etc... which are not systems designed to prevent and respond to child sexual abuse, but are nonetheless key to ensuring the safety of children. In addition, it is important that systemic advocacy occurs alongside on-the-ground services, enabling a 'translation' of individual experiences to system-level critique and change.

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?

There are a number of structural changes that should be implemented. Prevention is obviously better than the cure, especially in this context, so due attention should be paid to prevention. Additionally there are structural cultural impediments, such as stigma attached to victimisation and mental health issues, which can impede people coming forward to access services. These should be considered as part of prevention packages.

Other changes are well recognised: a 'no wrong door' approach; warm referrals; accessible information provided through a range of medium (not solely online); ensuring adequate capacity of services to ensure a timely and adequate response to a request for service; ensuring accessibility of all services so that people with disability don't have to 'ring around'. Others are less well recognised: in many cases, support services ask for medical proof of disability rather than using a social model of disability which understands the person to be expert in their own needs.

However, a collaborative approach to the provision of services is essential. The recently developed 'Safer Pathway' response to domestic violence in NSW⁴ may provide a useful model. It brings together a range of support services including housing, domestic violence services, health and so on, to develop a plan for an individual moving forward. This kind of approach would be useful for intake of child sexual assault victims, especially in the early stages, as the focus is on safety as well as treatment. However, it would also provide a useful model for adults, especially those survivors and victims who have multiple and/or complex needs whose interaction is poorly recognised by services.

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?

There is a need for better qualifications amongst those providing advocacy and support and/or therapeutic treatment for adult and child victims and survivors. A broader uptake of trauma-informed service provision training across all service sectors is essential. Disability competence should also be a required element of qualifications. Ongoing education in these areas should be a required part of professional development. Both original qualifications and ongoing training should include information about cross-sector collaboration.

There should also be an acknowledgement amongst counsellors and other therapists that for some survivors and victims seeking services, robust and high-level psychological treatment as provided by a university-qualified provider may be required, and should be sought. Similarly, for some survivors and victims, alternative forms of psychological support, provided by those experienced in providing therapy to people with disability, must be sought. Basic counselling Certificates and similar must involve a thorough discussion of when a client's needs exceed the counsellor's capacity. This

⁴ See http://www.crimeprevention.nsw.gov.au/domesticviolence/Pages/stopsHereSaferPathway/Safer_Pathway.aspx

would ensure that people with disability are not automatically and unnecessarily referred to 'specialist' services, but that those who need alternative forms of therapy such as art, narrative, play or music therapy, are provided with it.

This also means that there must be an increase in the number of higher level qualified workers, and these qualifications should include a good understanding of how to deliver services to people with disability, to people from diverse cultural and linguistic backgrounds, and to Aboriginal and Torres Strait Islander people. There is a dearth of adequately qualified counselling and psychological therapists in this area.

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?

Play, art and music therapy are innovative ways for victims and survivors to work through their trauma and begin healing. Few people with disability can access these alternative forms of therapy, however, and many of those who require alternative forms of therapy are denied access to any treatment as a result. We would recommend further engagement with WWILD, who have numerous counsellors as well as extensive research into counselling and psychological supports for people with disability.

2. What evaluations have been conducted on promising and innovative practices? What have the evaluations found?

Few evaluations have been conducted of innovative psychological practice, such as play, art and music therapy, in relation to people with disability. We would encourage the Royal Commission to make recommendations related to this area.

We thank the Royal Commission for the opportunity to make this submission.