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GPO Box 5283
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Submission to Royal Commission into Institutional Responses to Child Abuse: Advocacy and Support and Therapeutic Treatment Services

Thank you for the opportunity to make a submission on the best way to provide support, advocacy and treatment to survivors of childhood sexual abuse in institutional contexts.

We will begin by providing an overview of our organisation, Phoenix Australia – Centre for Posttraumatic Mental Health, our mission and our work. We will then go on to address the nominated questions outlined in issues paper 10.

Phoenix Australia – Centre for Posttraumatic Mental Health (phoenixaustralia.org)

Phoenix Australia – Centre for Posttraumatic Mental Health is a not-for-profit centre of excellence whose mission is to build the capability of individuals, communities and organisations to prevent, recognise, and reduce the adverse mental health effects of trauma.

Phoenix Australia has a longstanding track record of trauma research, policy and service development, and training initiatives across the Australian community. This is reflected in our role in developing the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder, which were approved by NHMRC and endorsed by the colleges of psychiatrists, psychologists and general practitioners; our work with local, state and commonwealth governments to develop and implement workforce development programs to support survivors of disaster; our work with the Departments of Defence and Veterans' Affairs to support the mental health of veterans and military personnel; research and intervention programs for survivors of traumatic injury; and initiatives with emergency service organisations, services supporting survivors of sexual assault, drug and alcohol treatment services, youth and homelessness agencies.

Phoenix Australia has worked with a range of organisations on trauma-related issues including Victoria Police, Centres against Sexual Assault (CASA), 1800 RESPECT, Youth Support and Advocacy Service (YSAS), Sacred Heart Mission, Vincent Care, MIND Australia, alcohol and drug services, community health services, Veterans and Veterans Families Counselling Service (VVCS), hospital-based Trauma Recovery Programmes, a number of area mental health services, Victorian Department of Education and Early Childhood Development, Parenting Resource Centre, headspace school support and, most recently, Victorian Department of Health and Human Services on trauma-informed care for clients with refugee and asylum seeker backgrounds.

We value collaboration and engagement with key stakeholders very highly. For example, we have worked with the professional colleges RACGP, RANZCP, APS, AASW, and AOT on a range of our projects.

Topic A: Victim and survivor needs and unmet needs

Research has consistently shown that childhood sexual abuse can have a severe impact on a person's emotional and physical wellbeing and can have long-term consequences for a person's ability to form relationships and to participate in work and in their community[1]. Childhood trauma, particularly when it is prolonged, can interrupt the emotional, social or cognitive development of a child and lead to problems such as anger and aggression, feelings of extreme anxiety and shame, and impulsive and self-destructive behaviours[2]. Depression and anxiety disorders are common responses, as well as posttraumatic symptoms such as an increased startle response, hypervigilance and nightmares. In children, these reactions can include engaging in play that re-enacts the trauma, nightmares about monsters or threats to self and family, regressive behaviours such as a return to bedwetting, an increase in tantrums or aggressive behaviours, or difficulties with learning[3].

This submission will focus on five issues that need to be addressed when delivering support and treatment services to survivors of childhood sexual abuse. These are issues likely to significantly impact on survivors' ongoing safety, their ability to access support services, or their long-term recovery. In addition, these issues have been selected because they have been difficult to address within the Australian health system. Suggestions for establishing new knowledge and/or improving services are also briefly outlined. The five priority issues are:

1. **Early identification –** Our understanding of the prevalence of childhood sexual abuse, and the barriers to disclosing abuse and accessing help, is mainly based on adults' reports of their childhood experiences. Experiences of abuse are disclosed on average more than a decade after the abuse has ended[4]. Early identification is not only crucial for ensuring that children are safe, but also to provide people affected by childhood sexual abuse with the best chance for recovery. There is now strong evidence that early intervention can help prevent the cumulative impacts of abuse and increase a person's ability to recover. While research indicates that some interventions such as mandatory reporting have had a positive impact on early identification and, to an extent, access to support[5], little is known about what promotes early identification and engagement in support services. Research in this area is urgently needed in order to ensure that the service system identifies people who require help as soon as possible.

2. **Re-victimisation –** A large number of studies have indicated that childhood sexual abuse is associated with the risk of experiencing sexual assault and other forms of traumatic experiences in adulthood[6]. Effective support needs to be able to address both the potential

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[1] Trickett, P., Noll, J., & Putnam, F. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology, 23*, 453-476; Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. Clin Psychol Rev, 29, 647–657.

[2] See footnote above; Ford, J. D. & Courtois, C. A. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. A. Courtois& J. D. Ford (Eds.), *Treating complex traumatic stress disorder* (pp. 13–30). New York, NY: Guilford Press.

[3] National Child Traumatic Stress Network. (2008). *Child trauma toolkit for educators.* Los Angeles, CA: National Child Traumatic Stress Network.

[4] McElvaney, R. (2015).Disclosure of child sexual abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review, 24*, 159-169. Paine, M. & Hansen, D. (2002) Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*, 271-295.

[5] Mathews, B. & Bross, D. (2008) Mandated reporting is still a policy with reason: empirical evidence and philosophical grounds. *Child Abuse and Neglect, 32*, 511-516.

[6] Trickett, P. K., Noll, J. G., & Putnam, F.W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology, 23*, 453-476. Mouzos J.

risk of re-victimisation and survivors' current safety concerns. While safety is a priority in specialist sexual assault services, mental health and general support services such as child and family services, there is no consistent definition or approach to assessment of risk in this area. A range of strategies could be considered to foster a more consistent approach to assessing risk and preventing re-victimisation, including making this topic a priority when promoting cross-sectoral collaboration projects and partnerships and the development of national guidelines, and a systematic implementation of these guidelines across sectors. The dissemination of consistent trauma-informed care education and programs would also be helpful in this area (see description of trauma-informed care under Topic E).

3. **Help seeking: need for safety and control –** Sexual abuse, particularly when perpetrated in the context of an institution by trusted adults, can undermine a person's trust in others and their sense of safety in the world. In addition, while recognition of the spread and impact of sexual abuse is growing in the community and in our health system, stigma is still a significant issue and cases of sexual abuse still go undetected in health services. These issues have a significant impact on survivors accessing and remaining in support services[7]. Accordingly, there has been a call for services to be trauma-informed and provide a safe environment and a coordinated response to those who have experienced childhood sexual abuse[8]. See suggestions under Topic E for a description of trauma-informed care.

4. **Access to best practice treatment –** Childhood sexual abuse is a traumatic experience that can have a significant impact on a person's emotional, physical and social development and lead to complex mental health issues[9]. Effective treatments for mental health problems resulting from developmental trauma exist, and an extensive literature and a number of treatment guidelines have been published[10] (effective treatments are described in Topic E). However, few people receive best practice treatment. For example, while it is common for survivors to be diagnosed with more than one mental health disorder, in Australia, few receive specialist treatment[11]. Only half of people who have comorbid mental health conditions access help, and most of these (80%) rely on their general practitioners (GPs) for support. In addition, Australian and international surveys have indicated that many practitioners working with adults are reluctant to use recommended treatments for posttraumatic mental health problems because they do not have access to training, do not feel confident in their use, or are worried about distressing their clients[12]. In an Australian study looking at the practice of workers in

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& Makkai T. (2004). Women's experiences of male violence: findings from the Australian component of the International Violence Against Women Survey (IVAWS*). Research and Public Policy Series 56*, Australian Institute of Criminology, Canberra

[7] Fallot, R. & Harris, M., 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol, Washington, DC: Community Connections, retrieved from: https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

[8] MHCC. (2013). Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia-a national strategic direction Mental Health Coordinating Council, Lilyfield, NSW.

[9] Paolucci, E., Genuis, M., & Violato C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 13*, 17-36.

[10] Australian Centre for Posttraumatic Mental Health (ACPMH). (2013). Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. Melbourne, Victoria: ACPMH.; Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults

[11] Summary of results from the 2007 National Survey of Mental Health and Wellbeing, extracted from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007

[12] Couineau A. & Forbes D. (2011). Using predictive models of behavior change to promote evidence-based treatment for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, Vol 3*, 266-275; Rosen, C. S., Chow, H. C., Finney, J. F., Greenbaum, M. A., Moos, R. H., Sheikh, J. I., & Yesavage, J. (2004). VA practice

child and family services, less than 5% of workers working with children who had experienced abuse identified that they delivered an evidenced-informed treatment[13]. Implementation of existing programs that have been shown to be effective (or, in the child treatment sector, promising), including a systematic evaluation of outcomes for survivors, should be the priority over the next few years.

5. **Addressing individual, family and community needs –** In some instances, whole communities are impacted by sexual abuse perpetrated by respected community members, and the prevalence of intergenerational trauma in some populations is high. Effective support services need to be able to address the needs of an individual survivor, their family, carers and community. At present, many of the specialist services working with survivors of childhood sexual abuse have an individual focus. Guidelines for family-inclusive, trauma-focussed practice have been disseminated across parts of the service system but have not been systematically targeted at sexual assault services[14].

Topic D: Service system issues

What do we know?

While there have been some state-based reports into gaps in the service system and a call for dedicated specialist agencies[15], little is known about experiences of the Australian health and welfare system by both adults and children who have experienced sexual abuse.
A systematic investigation of how services are accessed by and delivered to these groups is required in order to better understand why few receive best practice treatment and how to best promote access to safe and effective care. When considering the support and health care needs of survivors of childhood sexual assault, four groups need to be investigated:

1. Those who access multiple services over long periods of time. Because of the complex nature of the impact of childhood sexual abuse on mental health and on psychosocial functioning, many survivors access a number of services such as primary health, mental health and drug and alcohol services, often on multiple occasions.

2. As mentioned previously, the large number of people who have multiple mental diagnoses and related chronic health issues who rely solely on their GPs for support.

3. Those who approach the service system and are not identified as survivors of childhood sexual abuse and therefore do not have their needs met.

4. Children who are identified as being at risk under the child protection system.

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patterns and practice guidelines for treating posttraumatic stress disorder. *Journal of Traumatic Stress, 17*, 213-222.

[13] Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013). Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications. Report prepared for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

[14] The Bouverie Centre, La Trobe University. (2013). Guidelines for Trauma-Informed Family Sensitive Practice in Adult Health Services. Melbourne, Victoria: The Bouverie Centre.

[15] ACSSA Wrap No.1 - Sexual Violence Research: http://www3.aifs.gov.au/acssa/pubs/wrap/w1.html. Holden, T. (2002), It's still not my shame: Adult survivors of childhood sexual abuse report, Women's Health Statewide, Women and Children's Hospital, Adelaide.

Need for care coordination and more responsive entry points into system of care

Survivors of childhood sexual abuse access the service system from many points, including community mental health services, child protection, private allied health and medical professionals, GPs, hospitals, and specialist programs that deal with issues such as sexual assault, early psychosis, or drug and alcohol problems. The fragmented nature of service delivery and the lack of coordination amongst service providers has been identified as a potential source of distress, and leads to disengagement for people who have experienced trauma[16]. Care coordination has been a priority in mental health policy at both state and national levels, and several models of care coordination have been trialled and put in place to help those who have experienced violence and abuse[17]. In particular, there have been attempts across several states to have a cross-sectoral, multi-agency approach to investigating and supporting children who have been abused, such as the Multi-agency Investigation and Support Team (MIST) in Western Australia, and the Multidisciplinary Centres (MDCs) in Victoria, that bring police investigation teams and specialised support services or child welfare agencies together. However, these models have been trialled and delivered locally, and there does not appear to be a systematic approach at a state or national level to meet the specific needs of those who have been the victims of abuse, including childhood sexual abuse.

The role of GPs in care coordination and improving access to effective care is particularly important as they are a common entry point into services and the sole source of support accessed by many. While GPs have access to guidance such as the RACGP's clinical guidelines on sexual assault[18], which highlight the prevalence of childhood sexual abuse and the need to ask about past sexual assault history, there is evidence that, in Australia, few patients disclose their experience to GPs or are referred to specialist services. For example, in one study conducted in Victoria, only 9% out of 28% of women presenting to a general practice with a history of childhood sexual abuse disclosed their experience to their doctor. Another study reported that women who experienced childhood sexual abuse were much more likely to see their GP frequently yet be dissatisfied by their services[19].

Care coordination is particularly crucial in the mental health sector as survivors of childhood sexual abuse are known to be at higher risk for most of the serious mental health problems including psychosis, mood disorders, eating disorders, substance abuse, posttraumatic, anxiety and personality disorders. Of necessity, treatment is primarily managed around an individual's metal health condition rather than the actual childhood sexual abuse. This results in the need for mental health services dealing with these issues to be trauma-informed, accessible, holistic and well-coordinated.

Despite the prevalence of mental health problems in people who have experienced sexual abuse, the coordination between sexual assault specialist services and mental health services has been

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[16] Fallot, R. D., & Harris, M. (2001). A trauma-informed approach to screening and assessment. *New Directions for Mental Health Services. 89*, 23–31.
[17] E.g., coordinating bodies and service coordination positions created in Domestic violence in Victoria
[18] RACGP Clinical Practice Guidelines, chapter on sexual assault: http://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-9-sexual-assault/
[19] Mazza, D., Dennerstein , L. & Ryan, V. (1996). Physical, sexual and emotional violence against women: a general practice-based prevalence study. *Medical Journal of Australia, 164*,14-17; Coles, J., Lee A., Taft A., Mazza, D., Loxton, D, (2015). General practice service use and satisfaction among female survivors of childhood sexual abuse, *Australian Family Physician, 44*, 71-76.

hampered by differences in service models and skill base[20]. Several consultation, research and training projects aimed at reinforcing cross-sector partnerships and care coordination have been funded at local, state and national levels; however, few have been evaluated or implemented over the long term[21].

Support for delivery of best-practice treatment

As mentioned earlier, few practitioners in the current service system use evidence-based treatments. In addition, mental health treatment services do not have systems in place to recognise and address childhood sexual abuse. Finally, survivors of childhood sexual abuse who receive care from private practitioners under the Medicare system cannot access more than 10 treatment sessions. This is inadequate to address the complex treatment needs of people who have developed mental health problems following childhood abuse (see Topic E below). In order to improve the service system, the following issues should be considered.

- The need for systematic implementation of evidence-based programs, including education and training in identification of victims of childhood sexual abuse, clinical assessment skills, and evidence-based therapies.
- The development of funding models that support treatment of complex and chronic problems so that sufficient time is provided to foster client engagement and recovery.
- Quality assurance processes that specifically measure quality of delivery of recommended treatments, and outcomes for survivors of childhood sexual abuse.
- The need to develop clear and efficient pathways of care into, through, and beyond the service system (as mentioned earlier, there are many state-based care coordination models, but none specifically address the needs of childhood sexual abuse survivors).

Topic E: Evidence and promising practices

Trauma-informed care

Trauma-informed care (TIC) has been developed to ensure that health and support services are responsive to the needs of people who have experienced trauma, and it has been widely disseminated across the health and welfare sectors in Australia. TIC is based on the premise that many behaviours or responses expressed by clients accessing support services are related to and often exacerbated by the experience(s) of trauma, and that many common practices and policies in service systems inadvertently create environments that may lead to distress or even re-traumatise people with histories of trauma[22]. TIC aims to assist clients to engage in the service system by:

"emphasis(ing) physical, psychological and emotional safety for both providers and survivors, and that creates an opportunity for survivors to rebuild a sense of control and empowerment"[23]*.*

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[20] Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems (MHCC, 2006); Building partnerships between mental health, family violence and sexual assault services Project report (2006) Victorian Government Department of Human Services, Mental Health Branch, Melbourne, Victoria.
[21] See previous footnote
[22] Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*: Jossey-Bass.
[23] Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, p.82

TIC has been tailored to meet the needs of a range of people including those who have experienced childhood sexual abuse[24]. In Australia, there are a number of publications encouraging the use of TIC, as well as education resources and implementation projects[25]. However, rigorous evaluations of the TIC approach have not been conducted, particularly with regards to improvement of service accessibility and responsiveness for survivors of childhood sexual abuse.

Mental health treatment for adult survivors of childhood sexual abuse

People who have experienced childhood sexual abuse can experience a range of mental health issues. As mentioned previously, it is often the case that developmental traumas of this nature can lead to complex presentations with comorbid issues such as co-occurring depression, posttraumatic stress disorder (PTSD), and substance use. One of the most common mental health problems following sexual abuse is complex PTSD, which includes symptoms such as difficulties managing emotions, impulsive behaviours, dissociation, vivid and intrusive recollections of traumatic experiences, and nightmares. Effective treatment involves taking a sequential approach to managing problems, with the use of multiple interventions targeting the most prominent symptoms. Initial treatment involves stabilisation and ensuring patient safety, providing education about trauma, cognitive restructuring, and emotion regulation interventions. Medication may also be required to reduce symptoms and assist this process. This is then followed by interventions aimed at helping the person to process traumatic memories. The final phase of treatment involves helping the person to use the skills they have learned to better engage in relationships and study or work[26]. Client collaboration and engagement are key factors in facilitating this work, and for many clients who have experienced childhood sexual abuse[27], more time may be required to develop a trusting relationship with their therapist. Short-term models of care may therefore not be suited to many in this client group and, in some cases, may even be harmful. (For example, in people for whom rejection, abandonment, or minimisation of their experience are central to their difficulties, terminating a therapeutic relationship too soon can be detrimental. The ten sessions funded through Medicare for private allied health practitioners may therefore not be suitable.)

Mental health treatment for children who have experienced sexual abuse

As with adults, a significant number of children who have experienced childhood sexual abuse develop complex mental health problems. These may include anxiety, depression, posttraumatic stress symptoms, and associated behavioural problems such as substance abuse, aggression, disengagement from school, and risk taking.

Generally, the research into effective treatments for children affected by childhood sexual abuse lags behind what we know about what works for adult survivors. There are not many rigorous research trials and very little long-term follow-up data. Few findings in this area of research are replicated[28]. We also don't have enough information about how treatments impact on educational

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[24] E.g. National Child Traumatic Stress Network TIC implementation projects and resources: http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

[25] the National Strategic Direction Position Paper for TIC (MHCC, 2013), Bouverie paper, ACPMH and other projects

[26] Ford, J. D., & Courtois, C. A. (Eds.). (2013). *Treating Complex Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models*. New York, NY: Guilford Press; Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson,C. L., . . .Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry, 167*, 915–924.

[27] See footnote above

[28] Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013). *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications*.

outcomes or cognitive and physical development, when there is strong evidence that sexual abuse has a significant influence on learning and overall development. Finally, the majority of the evidence is around treatments for adolescent and school age children, with much less known about what is effective for pre-schoolers.

The aims of treatment programs that have some evidence for their effectiveness are varied. Some programs are specifically aimed at addressing posttraumatic mental health problems, while others focus on improving a range of outcomes for children including behaviour problems, aggression, neglect, out-of-home care, risk for abuse, and parenting received. The only treatment that has been shown to be effective long-term through replicated controlled trials is Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT), a trauma-focussed intervention that directly targets posttraumatic stress symptoms. This therapy involves teaching skills to children to manage their emotions and change their thinking, as well as helping them process traumatic memories. Parents are also involved in the treatment and are usually taught skills to manage their child's distress, and other parenting skills aimed at supporting their child's recovery[29].

Three intervention programs have shown promise in helping children who have experienced a range of abuse: Child-Parent Psychotherapy (CPP), Fostering Healthy Futures, and Project Support. All three programs have been evaluated and their effectiveness has been examined through a randomised control trial, but further studies need to be conducted to ensure the results reported are replicable and are maintained long-term[30]. None of these programs has been trialed in Australia.

There are also programs aimed at preventing abuse and/or its impacts, but most are aimed at supporting families and/or carers (e.g., foster carers) to prevent familial abuse and neglect. The only exception is the Fourth R program which is delivered in schools to children aged 3–8 years, and aims to aims to prevent child abuse, neglect, sexual abuse and domestic violence. Again, none of these programs has been evaluated in Australia and all require further research to be considered as evidence-based[31].

Phoenix Australia hopes that these thoughts are of some value, and we would welcome the opportunity to discuss our submission further.

Yours sincerely

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Report prepared for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

[29] Cohen, J., Deblinger, E., Mannarino, A., & Steer, R. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry,4*, 393–402; Deblinger, E., Mannarino, A., Cohen, J., & Steer, R. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 12*, 1474–1484.

[30] See footnote 28

[31] See footnote 28