Royal Commission into Institutional Responses to Child Sexual Abuse

Response to Issues Paper 10
Advocacy and Support and Therapeutic Treatment Services

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Response to Royal Commission Issues Paper 10: Advocacy and Support and Therapeutic Treatment Services

Topic A: Victim and survivor needs and unmet needs

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

SASS notes the following as effective supports for victims/survivors:

- Effective integrated service delivery processes to facilitate smooth referrals and ongoing communication between services;
- Options for individual and/or group work;
- Services that are local and accessible;
- Services that offer a therapeutic, trauma-informed practice model.[1] Trauma-informed services approach people from the standpoint of the question "What has happened to you?" rather than "What is wrong with you?"[2]
- Clients only needing to tell their story once to a single service provider.
- Client-driven services where the client has control over what happens next and at what point.
- Related to the above point, services and processes that work at the victim/survivors pace – for example SASS has found that many of our Royal Commission clients need time to have the legal and Royal Commission languages, systems and processes translated to them. This process cannot be rushed if the client is to feel safe, informed and supported. SASS notes that the Royal Commission and Knowmore have both been excellent in accommodating the amount of time clients may need to feel comfortable engaging with the Commission and telling their story.
- Provision of information in accessible formats for people of diverse cultural and language backgrounds, as well as literacy abilities, age, gender and life circumstances. This includes having information available in print and electronic form, as well as options to receive information verbally.
- Services that employ a mix of evidence-based practice (ie empirically tested methodologies – such as those funded under the Federal *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule [Better Access] initiative*) and best practice (ie the particular therapeutic methodologies and techniques utilised within and thought to constitute best practice by the sector, but which may not yet have undergone rigorous empirical testing).

As well as therapeutic counselling support, the following have all been found to be beneficial for sexual assault victims/survivors;

- Art therapy
- Yoga and relaxation sessions
- information on self-defence and anger management
- ability to borrow or access books on relevant subjects such as relationships and abuse
- practical assistance such as help with letters about compensation
- techniques for sleeping, relaxing, stress management, weight control, smoking cessation and increasing physical exercise[3]

On a related note, flexibility with regard to how funding is to be spent is also important – for example in addition to providing counselling and/or advocacy support to a client, the practitioner and client may decide that it would be beneficial for the client to access massages, or other similar relaxation/therapeutic practices.

Question 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?

SASS notes the following:

- Victims/survivors can be re-traumatised by having to re-tell their story to many different organisations or workers.
- Victims/survivors need access to qualified professionals (social workers, psychologists or counsellors) who are registered with the professional association pertaining to their area. Supporting sexual assault victims/survivors is a specialist area that requires workers to possess appropriate qualifications, experience and skills; workers who do not have these may at best be of no benefit to victims/survivors, and at worst risk re-traumatising them.
- Some therapeutic practices or techniques (such as prolonged exposure therapy – which involves a survivor telling the story of their trauma over and over again within therapy) have been shown to be of dubious effectiveness or even harmful to victims/survivors. Reiterating the above point, this highlights the need for therapeutic interventions to be delivered by qualified professionals who apply best-practice and/or evidence-based approaches.
- Victims/survivors need flexibility and better understanding within police processes and the judicial system – many victims/survivors (particularly those who have suffered historical abuse) may not be able to remember the exact details of their abuse. The legal system however requires precise details with regard to times, dates, locations, etc. The standard of evidence required is therefore often prohibitively high to enable victims/survivors to pursue justice.

The following points specifically concern the work of the Royal Commission in supporting victims/survivors.

- In SASS's experience there is a need for further clarity from the Royal Commission to victims/survivors about the limit of the Commission's scope and work. Telling their story to the Commission is a significant experience for victims/survivors – particularly for those who have not told their story before. Some victims/survivors may expect more of a response than is actually available within the Commission's scope. It is therefore suggested that the Royal Commission be cognisant of client's expectations, and clear to victims/survivors that the Commission's role is to listen, believe and validate a survivor's experience, but not to conduct investigations or prosecutions, nor to allocate compensation.
- SASS is also concerned that some victims/survivors may not receive appropriate support during or after engaging with the Commission. For example, when some victims/survivors first call the Commission they may be asked to tell their story – which can be extremely confronting, but may not necessarily have support available to them at this time. One solution to this would be to ensure that referrals to the Commission come in primarily through support services (so that the victims/survivors is already receiving support), or that information on and referrals to support services are made available to victims/survivors prior to asking them to tell their story to the Commission.
- SASS notes two further concerns; firstly that the Commission doesn't always refer victims/survivors to the appropriate local sexual assault service; and secondly that once a victim/survivor has engaged with the Royal Commission it is also unclear whether they are then case-managed by the Commission to ensure they are receiving the support they require.

Question 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 following key elements can all help facilitate service access for victims/survivors:

- Welcoming spaces.

- Culturally competent service structures, provision and staff (for Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities) (see further note on this below).
- Sensitive and accessible service provision for those of diverse genders, sexual orientation, circumstances and backgrounds.
- Disability accessible and sensitive service infrastructure and practices.
- Flexible opening hours – for example availability of appointments and support outside standard business hours.
- No fees for service use.
- Accessible referral and intake systems that facilitate a 'one-door, right-door' approach: so that all services (such as medical/health, parenting, alcohol and other drugs, mental health, etc) understand how to identify and refer sexual assault victims/survivors to appropriate support. Additionally the ability of victims/survivors to self-refer is critical.
- No or short waiting lists.
- Provision of information and support through various mediums – such as after-hours phone support; print information in a variety of languages; downloadable apps and websites; and verbal information.
- Provision of child care where the parent/carer is unable to arrange alternative child care for the duration of their appointment.
- Outreach to facilitate service delivery for rural communities.
- Options of male or female staff, and of differing ages where possible.
- Service access options to ensure anonymity of clients. For example, SASS recently supported a group of older male survivors who were participating in the Royal Commission. The survivors wanted to form and meet as a support group, but did not want to attend SASS during the daytime and potentially 'bump into' people they knew. SASS therefore explored options for the survivors' group to either meet after-hours at SASS - where they would be the only group at the service, or to meet at a different location. SASS also allows clients to only give their first name, or a pseudonym, if they are not comfortable sharing their full name. Anonymity is obviously a particularly pertinent issue in a small town or community, and for particular groups such as CALD or Aboriginal and Torres Strait Islander clients.
- For children or those requiring additional support (ie those with a disability) – the willingness or ability of parents/carers to engage with and bring the child to the service. This can be a particularly contentious issue where parents have separated and one parent does not support the child's access to the service; and/or where one parent is suspected to have sexually abused the child and therefore does not wish the child to access the service.

An additional point to note is that whilst most services strive to be culturally and diversity competent, the reality is that for small service providers, the provision of services to, for example, people from Aboriginal and Torres Strait Islander and/or CALD backgrounds, sex workers, transgender or intersex people, and people with a disability, can still remain a challenge. Issues of scale mean that within small communities there often aren't specialist services for diverse communities (for example a specialist CALD family violence/sexual assault service). To take the example of working with clients with intellectual disabilities; a small sexual assault service may only receive one or two clients each year who have an intellectual disability. This low number means that staff do not get the opportunity to build expertise in working with people with an intellectual disability, and it is can be harder to justify allocation of (what are generally limited) professional development budgets to build this when staff also need to be skilled in working with a variety of other groups (in addition to general professional development in, for example, practice methods and frameworks, technologies, assessment tools, effective advocacy, etc). It can then become a vicious cycle where a service is not fully equipped to cater for clients with a disability – and therefore receives low referrals – and staff therefore cannot not build skills in this area, and so on.

This is by no means to excuse services from providing sensitive and competent service provision to *all clients* – this should be the standard for all services. It is just indicated to highlight the practical challenges that can exist in meeting this standard.

Topic B: Diverse victims and survivors

Question 4. What would better help victims and survivors in correctional institutions and upon release?

SASS notes the following:

- Sexual assault support services should be provided by an independent organisation that works in collaboration with the correctional institution.
- Corrections staff should receive education and training in trauma-informed awareness at a minimum, and ideally specific training in trauma-informed correctional care.
- Confidentiality around sexual assault presents a significant issue for prisoners who are victims/survivors. Sexual assault services could therefore utilise privileged communication envelopes to correspond with prisoners – although this wouldn't guarantee complete anonymity as these may still need to be handed in to prison staff.
- During and after release ex-prisoners require one-on-one support with information and referral to support organisations.
- Post-release ex-prisoners require sensitivity from service providers regarding the reasons they were incarcerated. As many sexual assault services do not see sexual assault perpetrators, these services could instigate (as many do already) a simple screening process so that sexual assault perpetrators are streamed off and referred to an alternate, more appropriate service, without non-sexual assault offenders needing to disclose that they have been incarcerated.
- A series of structured groups – focusing on skills acquisition, trauma reduction and psycho-education – could be beneficial. Note that this would also be a positive program format to implement within correctional facilities.

Topic C: Geographic considerations

Question 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)?

In Tasmania there are three sexual assault service providers. Like other sexual assault support services, SASS is funded a certain amount to deliver services to a specified population, which for SASS is Southern Tasmania – amounting to approximately 250,000 people. Tasmania has the most regional and dispersed population of any state in Australia, with 58 per cent of the population living outside the greater capital city area.[4] Aside from SASS, there are no other sexual assault services in the Southern part of Tasmania. Whilst SASS aims to provide the highest quality service to the greatest number of clients (based on a prioritisation system according to client age and need), to best utilise available funding SASS has to concentrate funding allocations to clients who can access our Hobart-based centre, as it is challenging for SASS to engage with and provide support to victims/survivors in regional and remote areas due to the additional costs in travel and staff time. For example, providing counselling to one client in a rural/remote area can occupy a SASS counsellor for a full day, including travelling time. In this same period of time a SASS counsellor could have seen three other clients. Even where funding is available to enable counselling staff to travel to a rural area, a further challenge can exist in locating premises that are appropriate and available for the counselling session to take place (for example premises must be accessible to the community, private, comfortable and quiet). Clients must therefore have their own transport, know someone who can take them to their appointment, or be able to utilise public transport – the infrastructure for which is not very strong in Tasmania.

Unfortunately this does mean that often only limited support can be provided to clients in rural/remote areas (although anyone affected by sexual assault can still access 24 hour crisis support through SASS over the phone).

SASS has also explored the use of information and communication technology to engage with clients in rural areas – for example delivering counselling or support sessions via phone or video-link. This does offer some potential to overcome some of the barriers in providing sexual assault services to rural areas. However, in SASS's experience this can be challenging, as:

- Equipment set-up costs are prohibitively expensive;
- The connection must be secure – for example Skype is not appropriate as the connection can be hacked by a third party;
- Video or phone sessions do not meet the needs of many victims/survivors who feel more comfortable with a face-to-face counselling/support experience – for example building a relationship with a counsellor can be more challenging over a video or phone call;
- Video or phone sessions require particular staff skills different to those required for in-person counselling;
- Staff on both ends also require particular practical training in how to utilise the technology;
- Phone or video sessions are limited in how interactive they can be – such as the use of cards, or in the case of children toys and games; and
- These can be particularly challenging for children for whom face-to-face contact assists in concentration and bonding.

Where services are delivered through a local service provider (for example a local health service), some people may not feel comfortable accessing this due to privacy concerns. Many people in rural areas therefore prefer to attend services in larger locations away from their home communities.

A further challenge within rural areas is that populations in rural communities may be more static than in urban areas, and therefore alleged perpetrators may remain in and be integrated into the community – which can obviously be incredibly challenging for victims/survivors, and hinder their recovery.

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

- Additional funding within service contracts to provide for outreach work would go some way to address the challenges discussed above.
- Innovative outreach modalities like travel and premise-sharing with other service providers could also enable services based in capital or regional towns to travel to rural areas.
- Capacity building of local service staff (for example health workers) by a specialist sexual assault service could help to provide some support to clients in rural areas.

Topic D: Service system issues

Question 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?
An important element of SASS's advocacy and support element is supporting victims/survivors through police and judicial processes, including information and support with forensic medical

examinations (FMEs). We would therefore recommend that this crucial element of advocacy and support be included in the Commission's definition.

Question 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?
SASS notes the following:

Integrated service delivery systems offer the potential for a more effective, coordinated, victim/survivor centred and holistic response to sexual assault victims/survivors. For example, in Victoria, a series of multi-disciplinary centres,

> …enable a specialist response to sexual offences and child sexual abuse. The centres co-locate Child Protection practitioners with: Victorian Police Sexual Offences and Child Abuse Investigation Teams (SOCIT) - specialised investigative teams of detectives trained to provide a victim focused specialist investigative response to the complex crimes of sexual assault and child abuse; and Centres Against Sexual Assault (CASA) - government funded organisations which provide women, children and men who have experienced sexual assault access to comprehensive, timely support and intervention to address their needs.[5]

Further suggestions for improvements to the service system include:

- Sexual assault services partnering with specialised services such as migrant/refugee support services, or disability services, to build each other's capacity in better responding to sexual assault when working with particular communities/groups.
- Communication and collaboration at a governmental (not just service) level to ensure coordination of approaches, knowledge, messaging and funding.
- A shared language and framework throughout the service system.
- Recognition of sexual assault services within the Medicare mental health care plan scheme.
- Consideration of whether labelling sexual assault services as such is confronting to some clients – and therefore poses an access barrier. One alternative would be to remove the label altogether and re-label sexual assault support centres as trauma-support services.

Question 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?
SASS notes the following:

- Practitioners should receive regular professional supervision by qualified and skilled supervisors. Those working in specialised fields of care such as child sexual assault may require supervision and professional development relevant to their particular area of work.
- Practitioners should also receive professional development in areas such as trauma-informed practice; case management; counselling; advocacy; court/legal processes; gender-awareness and working with male survivors.
- It was also noted by SASS staff that accessing training can be a challenge for small states/regional locations, as training is often only offered in capital cities on the mainland.

Topic E: Evidence and promising practices

Question 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?

As discussed above, integrated systems of service delivery represent an innovative new practice model that are already showing promising results in Victoria.

Trauma-informed systems of care also represent an innovative approach to addressing sexual assault and responding to the needs of victims/survivors.

> A "trauma-informed" system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people… (Harris & Fallot, 2001). A "trauma informed" system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment.[6]

Such a system adopts a 'First Door/Right Door' approach, whereby every service and private enterprise in the system is an appropriate access point for individuals and families affected by sexual assault. Service providers are sensitive and responsive to these concerns, and other partners (e.g. local pharmacies) have the information they need to identify the signs of trauma, and make safely-managed, 'warm' referrals. Enhanced levels of connectedness among key service providers enables them to address client concerns in an integrated, holistic manner that reduces the need for costly, non-local interventions. Furthermore, a trauma-informed community is one with improved levels of trauma awareness and sensitivity, which assists individuals and families to cope with the effects of sexual assault, family violence and complex trauma, and engage more effectively with local support services.

Other innovative practices that are showing promising results include:

- Eye Movement Desensitization and Reprocessing (EMDR) Therapy

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[1] The Mental Health Coordinating Council defines a trauma-based approach as one that "primarily views the individual as having been harmed by something or someone (Bloom, S 1997:2000, p 71)" and that trauma-informed care and practice "is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services." Mental Health Coordinating Council (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*. Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, p.9. Available at: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

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[6] Jennings, A. (2004). *Models for developing trauma-informed behavioral health systems and trauma-specific services*. p. 15. Available at: http://www.theannainstitute.org/MDT.pdf