Submission from the

Truth Justice and Healing Council

Royal Commission into Institutional Responses to Child Sexual Abuse

Issues Paper No. 10 | **Advocacy and Support and Therapeutic Treatment Services**

26 May 2016

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Justice Peter McClellan AM
Chair
Royal Commission into
Institutional Responses to Child Sexual Abuse

Via email: solicitor@childabuseroyalcommission.gov.au

Dear Justice McClellan,

As you know, the Truth Justice and Healing Council (the Council) has been appointed by the Catholic Church in Australia to oversee the Church's response to the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission).

We now provide the Council's submission in response to the Royal Commission's tenth Issues Paper, on advocacy and support and therapeutic treatment options.

Yours sincerely

Neville Owen
Chair
Truth Justice and Healing Council

26 May 2016

Our Commitment

The leaders of the Catholic Church in Australia recognise and acknowledge the devastating harm caused to people by the crime of child sexual abuse. We take this opportunity to state:

- Sexual abuse of a child by a priest or religious is a crime under Australian law and under canon law.
- Sexual abuse of a child by any Church personnel, whenever it occurred, was then and is now indefensible.
- That such abuse has occurred at all, and the extent to which it has occurred, are facts of which the whole Church in Australia is deeply ashamed.
- The Church fully and unreservedly acknowledges the devastating, deep and ongoing impact of sexual abuse on the lives of the victims and their families.
- The Church acknowledges that many victims were not believed when they should have been.
- The Church is also ashamed to acknowledge that, in some cases, those in positions of authority concealed or covered up what they knew of the facts, moved perpetrators to another place, thereby enabling them to offend again, or failed to report matters to the police when they should have. That behaviour too is indefensible.
- Too often in the past it is clear some Church leaders gave too high a priority to protecting the reputation of the Church, its priests, religious and other personnel, over the protection of children and their families, and over compassion and concern for those who suffered at the hands of Church personnel. That too was and is inexcusable.
- In such ways, Church leaders betrayed the trust of their own people and the expectations of the wider community.
- For all these things the Church is deeply sorry. It apologises to all those who have been harmed and betrayed. It humbly asks for forgiveness.

The leaders of the Catholic Church in Australia commit ourselves to endeavour to repair the wrongs of the past, to listen to and hear victims, to put their needs first, and to do everything we can to ensure a safer future for children.

Authorising Church Bodies

The following Catholic Church bodies have authorised the Truth Justice and Healing Council to represent them at the Royal Commission:

Dioceses

Archdiocese of Adelaide
Archdiocese of Brisbane
Archdiocese of Canberra-Goulburn
Archdiocese of Hobart
Archdiocese of Melbourne
Archdiocese of Perth
Archdiocese of Sydney
Diocese of Armidale
Diocese of Ballarat
Diocese of Bathurst
Diocese of Broken Bay
Diocese of Broome
Diocese of Bunbury
Diocese of Cairns
Diocese of Darwin
Diocese of Geraldton
Diocese of Lismore
Diocese of Maitland-Newcastle
Diocese of Parramatta
Diocese of Port Pirie
Diocese of Rockhampton
Diocese of Sale
Diocese of Sandhurst
Diocese of Toowoomba
Diocese of Townsville
Diocese of Wagga Wagga
Diocese of Wilcannia-Forbes
Diocese of Wollongong
Eparchy of Ss Peter & Paul Melbourne
Maronite Catholic Diocese of St Maroun
Military Ordinariate of Australia
Personal Ordinariate of Our Lady of the Southern Cross

Religious Institutes

Adorers of the Blood of Christ
Augustinian Recollect Sisters
Augustinian Sisters, Servants of Jesus & Mary
Australian Ursulines
Benedictine Community of New Norcia
Blessed Sacrament Fathers
Brigidine Sisters
Canons Regular of Premontre (Norbertines)
Canossian Daughters of Charity
Capuchin Friars
Christian Brothers
Cistercian Monks
Columban Fathers
Congregation of the Mission – Vincentians
Congregation of the Most Holy Redeemer – Redemptorists
Congregation of the Passion – Passionists
Congregation of the Sisters of Our Lady Help of Christians
Daughters of Charity
Daughters of Mary Help of Christians
Daughters of Our Lady of the Sacred Heart
Daughters of St Paul
De La Salle Brothers
Discalced Carmelite Friars
Dominican Friars
Dominican Sisters of Eastern Australia & The Solomons
Dominican Sisters of North Adelaide
Dominican Sisters of Western Australia
Faithful Companions of Jesus
Family Care Sisters
Franciscan Friars
Franciscan Missionaries of Mary
Franciscan Missionaries of the Divine Motherhood
Franciscans of the Immaculate
Holy Cross – Congregation of Dominican Sisters
Holy Spirit Missionary Sisters
Hospitaller Order of St John of God
Institute of Sisters of Mercy Australia & Papua New Guinea
Loreto Sisters
Marist Brothers
Marist Fathers Australian Province
Marist Sisters – Congregation of Mary
Ministers of the Infirm (Camillians)
Missionaries of God's Love
Missionaries of the Sacred Heart
Missionary Franciscan Sisters of the Immaculate Conception
Missionary Sisters of Mary, Queen of the World
Missionary Sisters of St Peter Claver
Missionary Sisters of Service
Missionary Sisters of the Sacred Heart
Missionary Sisters of the Society of Mary
Missionary Society of St Paul
Oblates of Mary Immaculate
Order of Brothers of the Most Blessed Virgin Mary of Mount Carmel (Carmelites)
Order of Friars Minor Conventual
Order of Saint Augustine
Order of the Friar Servants of Mary (Servite Friars)
Our Lady of the Missions
Patrician Brothers
Pious Society of St Charles – Scalabrinians
Poor Clare Colettines
Presentation Sisters – Lismore
Presentation Sisters – Queensland Congregation
Presentation Sisters – Tasmania
Presentation Sisters – Victoria
Presentation Sisters – Wagga Wagga Congregation
Presentation Sisters – WA
Religious of the Cenacle
Salesians of Don Bosco
Salvatorian Fathers – Society of the Divine Saviour
Secular Institute of the Schoenstatt Sisters of Mary
Servants of the Blessed Sacrament
Sisters of Charity of Australia
Sisters of Jesus Good Shepherd "Pastorelle"
Sisters of Mercy Brisbane
Sisters of Mercy North Sydney
Sisters of Mercy Parramatta
Sisters of Nazareth
Sisters of Our Lady of Sion
Sisters of St Joseph
Sisters of St Joseph of the Apparition
Sisters of St Joseph of the Sacred Heart
Sisters of St Joseph, Perthville
Sisters of St Paul de Chartres
Sisters of the Good Samaritan
Sisters of the Good Shepherd
Sisters of the Holy Family of Nazareth
Sisters of the Little Company of Mary
Sisters of the Resurrection
Society of African Missions
Society of the Catholic Apostolate (Pallottines)
Society of Jesus
Society of St Paul
Society of the Divine Word Australian Province
Society of the Sacred Heart
Sylvestrine-Benedictine Monks
Ursuline Missionaries of the Sacred Heart
Verbum Dei Missionary Fraternity

Other Entities

Australian Catholic Bishops Conference
Catholic Religious Australia
Catholic Church Insurance Limited
National Committee for Professional Standards
Professional Standards Office Tasmania
Professional Standards Office NSW/ACT
Professional Standards Office NT
Professional Standards Office Qld
Edmund Rice Education Australia
Good Samaritan Education
Kildare Ministries
Loreto Mandeville Hall Toorak
Trustees of Mary Aikenhead Ministries

The Truth Justice and Healing Council

1 The Catholic Church in Australia (the Church) welcomes the establishment of the Royal Commission into Institutional Responses to Child Sexual Abuse as an opportunity to acknowledge the truth about child sexual abuse within the Church, and to have these issues investigated and considered, objectively and publicly. It is an opportunity to bear witness to the suffering of the many victims of this abuse.

2 The Church is committed to cooperating with the Royal Commission, without reservation or qualification.

3 In February 2013 the Australian Catholic Bishops Conference (ACBC) and Catholic Religious Australia (CRA)[1] jointly established the Truth Justice and Healing Council (the Council) to coordinate and oversee the Church's overall response to and appearance at hearings of the Royal Commission.

4 The Council is a body of 11 people, with expertise spanning such fields as child sexual abuse, trauma, mental illness, suicide, psycho-sexual disorders, education, public administration, law and governance. The majority of Council members are lay, two of its members are bishops, and one of its members is a Brigidine sister. A number of the Council members have direct personal experience of sexual abuse of children in the Church. The Council provides independent advice to the ACBC and CRA, through a Supervisory Group, which is comprised of the Permanent Committee of the ACBC, and representatives of CRA. The Supervisory Group may accept or reject the advice.

5 The Supervisory Group endorses this Submission. The members of the Supervisory Group are listed on the TJHC website here.

6 The Council is chaired by the Hon Neville Owen, former judge of the Supreme Court of Western Australia and former HIH Royal Commissioner. Mr Owen's appointment follows the death of the Council's inaugural Chair, the Hon Barry O'Keefe in April 2014.

7 The other members of the Council are:

- Ms Elizabeth Proust AO, Deputy Chair, former Secretary to the Victorian Department of Premier and Cabinet, Chairman of the Bank of Melbourne, Nestlé Australia, and the Institute of Company Directors, and a member of other boards
- Archbishop Mark Coleridge, Archbishop of Brisbane
- Professor Maria Harries AM, Adjunct Professor at Curtin University and Research Fellow in Social Work and Social Policy at the University of Western Australia

[1] CRA is the peak body, previously known as the Australian Conference of Leaders of Religious Institutes, for leaders of religious institutes and societies of apostolic life resident in Australia.

- Professor Rosemary Sheehan AM, Department of Social Work, Faculty of Medicine, Nursing and Health Sciences, Monash University
- Hon Greg Crafter AO, former South Australian Minister of Education
- Sr Maree Marsh, former Congregational Leader of the Brigidine Sisters and psychologist with Anti-Slavery Australia at the University of Technology Sydney, Faculty of Law
- Bishop Bill Wright, Bishop of the Diocese of Maitland-Newcastle
- Professor Greg Craven, Vice-Chancellor of the Australian Catholic University
- Mr Stephen Elder OAM, former Member of the Victorian Legislative Assembly and Parliamentary Secretary for Education and currently Executive Director of Catholic Education for the Archdiocese of Melbourne
- Dr Marian Sullivan, child and adolescent psychiatrist.

8 The CEO of the Council, Mr Francis Sullivan, has worked in government and private practice and has held positions as Secretary-General of the Australian Medical Association, Chief Executive of Catholic Health Australia and consultant to the Pontifical Council for the Pastoral Care of Health Care Workers at the Vatican. He is an Adjunct Professor at the Australian Catholic University.

9 The Council oversees the Church's engagement with the Royal Commission, including by:

- speaking for the Church in matters related to the Royal Commission and child sexual abuse
- coordinating the Church's legal representation at, and the Church's participation in, the Royal Commission.

10 The Council's role extends to:

- initiating research into best practice procedures, policies and structures to protect children
- assisting in identifying any systemic institutional failures that have impeded the protection of children
- providing information to the Royal Commission concerning the various procedures, policies and structures that have been successively put in place by Church organisations over the past 25 years to deal with complaints and instances of child sexual abuse and any improvements which might be made to them to provide greater protection for children
- seeking to promote lasting healing for the victims and survivors of abuse.

11 To date, 32 dioceses and 97 religious institutes (commonly referred to as congregations and orders) have given an authorisation to the ACBC or CRA, authorising those bodies to represent and act for them in the engagement of the Church with the Royal Commission.

12 The ACBC and CRA have in turn delegated that authority to the Council. The Council therefore seeks to appear at the Royal Commission for all the authorising bodies, and will speak with one voice for all of them.

13 Pursuant to these arrangements, the Council acts for all archdioceses and dioceses in Australia, with the exception of three of the Eastern Rite Eparchies, and for all the major religious institutes. The Council also acts for a number of other Catholic organisations including Catholic Church Insurance Limited (CCI).

14 For practical purposes, the Council will ordinarily speak for the whole Church: its dioceses, its religious institutes, its priests and religious, in the Royal Commission.

15 The Catholic Church in Australia today is an extensive and diverse religious organisation committed to worship, prayer and pastoral care. It is involved in providing pastoral, educational, health, human and social services across Australia.[2]

16 Notwithstanding that all the dioceses and religious institutes are autonomous and independent, each from the other, with no one central or controlling authority, and with each free to govern its affairs separately and independently, all are united in their support for the principles stated in the Commitment at the head of this Submission.

17 Those principles are also fully shared by all the innocent and high-minded priests and religious whose long years of devoted and selfless service have been admirable and who are heartbroken by the revelations of sexual abuse which have emerged in recent decades.

18 The Council's aim is to do everything in its power to ensure that the Royal Commission has available to it from the Church all the material that it needs for the work it seeks to do, so as to ensure that a light is shone on dark places and times and events, and to ensure that nothing is concealed or covered up in respect of what Church personnel did or failed to do.

19 The Council seeks to fulfil that role, on behalf of the Church, in a spirit of honesty, openness and genuine humility.

[2] See Annexure B, TJHC Submission to Royal Commission Issues Paper No 2: Towards Healing, 30 September 2013 http://tjhcouncil.org.au/media/39435/30549468_2_TJHC-Towards-Healing-submission-30-Sep-2013.pdf

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Summary

1 Through Issues Paper No 10 the Royal Commission is seeking suggestions on how to improve advocacy and support and therapeutic treatment services for adult survivors of child sexual abuse (CSA). The topics for consultation are:

- Victim and survivor needs and unmet needs;
- Diverse victims and survivors;
- Geographic considerations;
- Service system issues, and
- Evidence and promising practices.

2 A clear definition of abuse is essential, including the spectrum of behaviours that are sexually abusive, both contact and non-contact abuse, involving a person who is in a position of power, and using that position to involve a child in unwanted sexual activity, and the subsequent effects of that abuse on the lives of adults.

3 This submission touches on the unique themes in disclosure for male and female survivors. It also looks at the complexities surrounding disclosure including the impact of negative reactions.

4 There should be consistent and informed knowledge about the issue of power and its dynamics in CSA, including disempowerment, disconnection and disabling of the basic capacities for trust, autonomy, initiative, identity, competence and intimacy.

5 Power needs to be understood as central to CSA not simply because the perpetrator wants to exercise power over a child, but also because they have the ability to exercise that power. The guiding principle of recovery is to restore power and control to the survivor through therapeutic processes which are designed to treat the effects of trauma experiences.

6 The concept of recovery is central to treatment of CSA. Practitioners must focus on the impact of social determinants of health, as well as on symptoms, and consider environmental, economic, social and political factors and how they influence a survivor's experience of abuse.

7 There are as many different types of therapeutic interventions or treatments as there are practitioners. Rather than landing on a particular therapy, the Council supports access to a range of therapies and approaches to the care and treatment of people living with the impact of CSA.

8 Victims and survivors should get access to high quality sophisticated services that are readily accessible. These services must be sensitive to and be able to integrate biological, psychological and sociological factors in each survivor's situation as traumatic experiences rarely exist in isolation.

9 To focus purely on CSA and not understand the influence of CSA in perpetuating or precipitating other existing psychological disorders is to deny survivors integrated care.

10 Effective campaigns are needed to counter perceptions which:

- blame victims
- diminish the responsibility of perpetrators
- perpetuate re-victimisation
- suggest children are most often abused by strangers (the majority are abused by someone they know)
- suggest that perpetrators are predominantly paedophiles (which suggests CSA is a form of sexual deviance which it is, but it is primarily an abuse of power), and
- focus attention on a 'kind of person' rather than kinds of behaviour, such as entrapment, grooming and control of children and the production and consumption of child pornography.

11 Public campaigns should be comprehensive and:

- be developed in consultation with survivors
- invite the community, but particularly men to take a stance against abuse, and
- raise the profile of the complex and varied experiences of abuse of survivors.

12 Many people do not present to support services with sexual abuse as the lead or even stated issue. Instead they present for a range of reasons such as family breakdown, homelessness, addiction or mental health problems.

13 Treatment and support should also be available to families and other secondary victims and should be sensitive to the impact of abuse on spirituality and gender and cultural differences.

14 Challenges to providing support outside metropolitan areas include distance and isolation, limited reliable communication and other technologies, lack of access to crisis care, and financial hardship.

15 The Council supports a nationally consistent approach to clinical supervision, training and professional development provided by accredited professional bodies. Some important points to consider in both services and therapy for survivors of CSA are:

- choice and options regarding services and support
- validating the survivor's experience
- use of non-judgemental language
- recognising and responding to the diversity of victims' cultural and linguistic background, disability, sexual orientation, age and geographical location
- communicating and sustaining hope and respect
- facilitating disclosure without overwhelming the client
- having a broad knowledge of trauma theory.

16 A therapeutic case management model with experienced clinical practitioners (preferably social workers) who are not providing the therapy but assessing need and providing support will help ensure victims and survivors receive the coordinated services and care they need. Therapists must be adequately trained, including in trauma-informed practice.

Foreword

1 The Truth Justice and Healing Council welcomes this opportunity to engage with the Royal Commission into Institutional Responses to Child Sexual Abuse in response to *Issues Paper No 10: Advocacy and Support and Therapeutic Treatment Services* on behalf of the Catholic Church in Australia. In particular the Royal Commission is seeking suggestions on how to improve advocacy and support and therapeutic treatment services for adult survivors of CSA. The topics for consultation are:

- Victim and survivor needs and unmet needs
- Diverse victims and survivors
- Geographic considerations
- Service system issues, and
- Evidence and promising practices.

Support Services

2 The Council notes the Royal Commission's definition of support services.

3 Many victims and survivors of CSA seek support outside of family and friends. Advocacy and support and therapeutic treatment encompass a range of services victims and survivors need to address the impact of CSA and trauma as well as assist them to heal and lead a fulfilling and meaningful life.

Advocacy and Support

4 The Council notes the Royal Commission's explanation of advocacy and support.

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

Therapeutic Treatment

6 The Council notes the Royal Commission's explanation of therapeutic treatment.

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

Victims and Survivors

8 The Royal Commission defines victims and survivors as:

- Children who experience contemporary abuse;
- Older victims and survivors; and
- Secondary victims.

9 The Royal Commission also identifies diverse groups which include:

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse backgrounds (CALD)
- People with a disability
- Men
- Care Leavers
- Lesbian, gay, bisexual, transgender and intersex people (LGBTI), and
- Victims and survivors who spent time in correctional facilities.

10 This submission seeks to provide a Church consensus on the broad issues raised by the Royal Commission in Issues Paper No 10, noting that this involves integrating elements which vary considerably across Church and other support organisations.

11 This submission made by the Council on behalf of the Church is informed by input from a number of dioceses and religious orders and from their professional standards offices and social services agencies, including specifically:

- South Australian Office of Professional Standards
- Western Australian Office of Professional Standards
- CatholicCare Social Services, Diocese of Parramatta
- Catholic Education Office, Centacare, Diocese of Cairns
- Christian Brothers Oceania Province
- Jesuit Social Services
- Former child protection officer and response coordinator from the Diocese of Rockhampton
- Zimmerman Services, Diocese of Maitland Newcastle
- Carelink, Catholic Archdiocese of Melbourne

12 While the submission is not footnoted, the research used to inform this work is included in a list of references at appendix 1.

13 Included in the submission are anecdotes from service providers in the Catholic network, which will provide some additional insight into the work of the sector and the experiences of people who seek assistance.

Topic A: Victim and survivor needs and unmet needs

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

1 Kezelman et al (2015:50) suggests that "active timely and comprehensive intervention with appropriate support, resources, services and treatment enables adult survivors of CSA to participate more fully and productively in the Australian community". For this to occur it is submitted the following are needed:

- active investment in specialist services,
- more and specially trained treating practitioners,
- convenient and failsafe pathways to treatment (clear processes), and
- systems, services and institutional improvements (trauma-informed practice).

Consistent definition of child sexual abuse (CSA)

2 There is a need for a consistent definition of CSA in Australia. A complexity in negotiating the issue of CSA and its effects on adult survivors is the lack of consistent and thorough definitions. Such a definition should include the spectrum of behaviours that are sexually abusive, both contact and non-contact abuse, involving a person who is in a position of power, and using that position to involve a child in unwanted sexual activity, and the subsequent effects of that abuse on the lives of adults.

Sexual abuse

3 Defining sexual abuse is a complicated task. Although some behaviours are considered sexually abusive by almost everyone (eg the rape of a 10-year-old child by a parent), other behaviours are seen by many to be much more equivocal (eg consensual sex between a 19-year-old and a 15-year-old), and judging whether or not they constitute abuse requires a sensitive understanding of a number of definitional issues specific to CSA.

4 In places such as Australia where there are multiple legal definitions of CSA, a more general definition may be useful. The World Health Organization (WHO) defines CSA as:

> *the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to ... or that violates the laws or social taboos of society. CSA is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.*

5 Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography.

6 However, unlike other maltreatment types, the definition of CSA varies depending on the relationship between the victim and the perpetrator. For example, any sexual behaviour between a child and a member of their family (eg parent, uncle) would always be considered abusive, while sexual behaviour between two

adolescents may or may not be considered abusive, depending on whether the behaviour was consensual, whether any coercion was present, or whether the relationship between the two young people was equal. Thus, in this paper, different definitions are presented for each class of perpetrator: adults with no familial relationship to the child, adult family members of the child, adults in a position of power or authority over the child (eg teacher, doctor), adolescent or child perpetrators, and adolescent or child family members.

7 For a visual representation of the different contexts and relationships in which child abuse occurs, refer to *Conceptualising CSA*.

Adults with no familial relationship to the child

8 Any sexual behaviour between a child under the age of consent and an adult is abusive (the age of consent is 16 years in most Australian states; see *Age of Consent Laws* for a more detailed discussion). Therefore, in Australia, consensual sexual activity between a 20-year-old and a 15-year-old is considered abusive, while in most jurisdictions the same activity between a 20-year-old and a 17-year-old is not considered abusive.

Online sexual abuse

9 Communication technologies facilitate a range of sexually abusive behaviours, and allow perpetrators to have anonymous contact with a large number of children. Forms of perpetration include grooming children in a virtual environment such as through instant messaging or voice-over-Internet-protocol, accessing child exploitation material, and producing and distributing exploitation material even where there is no sexual interest in children.

10 Online sexual abuse behaviours are often active with perpetrators seeking out minors online, and perpetrators may move from making connections with children online to making contact offline.

Family members of the child

11 Any sexual behaviour between a child and an adult family member is abusive. The concepts of consent, equality and coercion are inapplicable in instances of intra-familial abuse.

Adults in a position of power or authority over the child

12 Sexual abuse occurs when there is any sexual behaviour between a child and an adult in a position of power or authority over them (eg, a teacher). The age of consent laws are inapplicable in such instances due to the strong imbalance of power that exists between children and authority figures, as well as the breaching of both personal and public trust that occurs when professional boundaries are violated.

Adolescent or child perpetrators

13 Sexual abuse is indicated when there is non-consensual sexual activity between minors (eg a 14-year-old and an 11-year-old), or any sexual behaviour between a child and another child or adolescent who - due to their age or stage of development - is in a position of power, trust or responsibility over the victim. For example, any sexual activity between a 9-year-old and a 15-year-old would be considered abusive as the age difference between the two children leads not only to marked developmental differences, but also disparities in their levels of power and responsibility within their relationship.

14 Another example of abuse due to an imbalance of power would be sexual activity between two 15-year-olds, where one suffers an intellectual disability that impairs their ability to understand the behaviours that they are

engaging in. Normal sexual exploration between consenting adolescents at a similar developmental level is not considered abuse.

Adolescent or child family members

15 Sexual abuse occurs when there is sexual activity between a child and an adolescent or child family member that is non-consensual or coercive, or where there is an inequality of power or development between the two young people. Although consensual and non-coercive sexual behaviour between two developmentally similar family members is not considered CSA, it is considered incest, and is strongly proscribed both socially and legally in Australia.

Consistent response to disclosure

16 Along with a consistent definition of CSA the Council supports a consistent response to disclosures made by survivors across services, practice, policy, and research.

Disclosure is often extremely difficult for survivors

17 Research has shown there are unique themes in disclosure for male and female survivors. For men the themes that inhibited or precipitated disclosure were sex or gender related: fear of being seen as homosexual, feelings of isolation due to the belief that boys are rarely victims, and fear of becoming an abuser. For women, difficulties in disclosing appear to be related to internal confusion about who was responsible for the abuse as well as fears of being blamed or not being believed.

18 Negative reactions and responses to disclosure are common and can lead to secondary traumatisation.

19 Survivors have indicated that some counsellors have advised them to not speak out and just move on with their lives. This may be because the counsellor does not know how to respond. There need to be more individual practitioners with knowledge and expertise in this area.

20 A further complexity in relation to adult survivors of CSA is the time delay often involved in adult disclosures. This delay is not viewed within the context of the effects of abuse, which invite shame and blame for survivors, but rather it is often used to discredit the disclosure.

21 The Council commends to the Royal Commission, the practice guidelines for disclosure developed in an Australian context in consultation with survivors by Van Loon & Kralik (2005) which suggest a professional hearing a disclosure of CSA should:

- be approachable and understanding,
- have an open, honest and transparent professional agenda,
- be interested and engaged ,
- provide a supportive safe environment,
- be willing to listen non-judgmentally,
- receive the client’s story in a calm manner, and not dramatise or treat the story as unspeakable, and
- maintain confidentiality.

Consistent and informed knowledge of power and its dynamics

22 In addition to a consistent and thorough definition and consistent and informed responses to disclosure, there should be consistent and informed knowledge about the issue of power and its dynamics in CSA.

23 The fundamental experiences of sexual trauma in childhood are disempowerment, disconnection and disabling of the basic capacities for trust, autonomy, initiative, identity, competence and intimacy. As a result, given the impact on the core issue of trust and safety, survivors are harder to engage with therapeutically than other traumatised groups.

24 Power and opportunity are central to CSA. Power needs to be understood as central to CSA not simply because the perpetrator wants to exercise power over a child, but they have the ability to exercise that power.

25 Practitioners must be mindful of the dynamics of power in CSA and the subsequent effects of these dynamics on ASCSA so that they avoid replicating the dynamics of power in therapeutic relationships. A survivor should be consulted about their wishes and offered as much choice as possible while preserving their safety. Restoring control of their life to a survivor is central in any treatment modality.

26 ASCSA will have a range of experiences of abuse. The guiding principle of recovery is to restore power and control to the survivor through the therapeutic process.

Recovery from childhood trauma is possible

27 There are some frameworks and theoretical perspectives that can guide the development of consistent informed and helpful responses to ASCSA.

28 The Commonwealth Government has established a National Mental Health Strategy, with a number of corresponding documents:

- The National Standards for Mental Health Services
- A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory, and
- Implementation Guidelines for Non-Government Community Services 2010.

29 These documents identify a number of standards and a recovery oriented framework required to better support individuals living with mental illness. Whilst these are not specific to ASCSA, given the lack of standards and guidelines available for working with survivors, these may be applicable.

30 Some standards relevant to ASCSA which support the points in this submission are:

- Standard 1. Rights and Responsibilities
- Standard 2. Safety
- Standard 3. Consumer and Carer Participation
- Standard 4. Diversity responsiveness, and
- Standard 5. Promotion and prevention (Implementation Guidelines for Non-Government Community Services 2010).

31 The concept of recovery is central to treatment of adult survivors of CSA. Practitioners must focus on the impact of social determinants of health, as well as on symptoms, and consider environmental, economic, social and political factors and how they influence a survivor's experience of abuse.

32 Recovery will be difficult if other social determinants of health are involved 'Recovery occurs within a web of relations, including the individual, family and community, and is contextualised by culture, privilege or oppression, history and the social determinants of health. Recovery also occurs within the context of gender, age, and developmental stages'.

33 CSA occurs within a social and a political context, and there are views within some communities and individuals which lay the stigma and blame firmly at the feet of survivors/victims. Without knowledge of this social and political context, therapists can re-affirm the stigma and the myths related to victims/survivors of CSA and indeed perpetrators. Myths such as a person who was abused in childhood is irreparably damaged, permeate practitioners' views and discount the many thousands of survivors who live their lives and find ways of managing the effects of abuse in their lives without the support of mental health services.

34 The Council commends Judith Herman's three-stage model to the Royal Commission. The stages are:

- Safety and Stabilisation;
- Remembrance and Mourning; and
- Reconnection.

35 The primary task of safety and stabilisation is to ensure that survivors are safe physically, emotionally, and in their own bodies. Many survivors experience triggers and flashbacks which can be deeply disturbing, re-traumatising, and result in a survivor being in constant fight/flight mode. The practitioner must therefore establish a safe environment for the survivor.

36 Connection with the practitioner and a strong therapeutic alliance are essential in work with adults surviving CSA. These are also widely known to be reliable indicators of effectiveness.

37 Remembrance and mourning is the process where a survivor may reconstruct the story of abuse. This may not happen in one visit, pieces of the story may be told over a longer period of time. Without safety and stabilisation it would be unethical for practitioners to proceed with this stage. Here the practitioner bears witness to the survivor's story, in whatever way the survivor chooses to tell it.

Modalities

38 There are as many different types of therapeutic interventions/modalities as there are practitioners.

39 Rather than landing on a particular therapy, the Council supports access to a range of therapies and approaches to the care and treatment of people living with the impact of CSA.

40 Victims and survivors should get access to high quality sophisticated services that are readily accessible with clear pathways. These services must be sensitive to and be able to integrate biological, psychological and sociological factors in each survivor's situation as traumatic experiences rarely exist in isolation.

41 To focus purely on CSA and not understand the influence of CSA in perpetuating or precipitating other existing psychological disorders is to deny survivors' integrated care.

42 CSA should not be viewed in isolation from survivors' other life experiences and health problems.

Trauma-informed services and Trauma-specific services

43 Practitioners must be trauma informed and be able to help survivors identify comprehend and respond to the impact of CSA on their lives.

44 Trauma-informed services are aware of and sensitive to the impact of trauma. They do not treat trauma directly, but recognise the possibility of trauma in their client group. A trauma-informed service is one which:

- applies this 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 re-traumatisation and facilitate consumer participation in treatment, and
- requires (to the extent possible) close collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical experience in 'traumatology'.

45 Trauma-specific services are designed to directly treat the effects of trauma experiences and emphasise:

- Client and support worker safety, both physical and emotional, and
- The importance of respect for clients, provision of information, possibilities for connection and installation of hope.

46 In addition there needs to be an appreciation of complex trauma and an understanding of the various therapies available.

1.2 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?

47 The following have been found to be harmful for those affected by CSA:

- shame and trauma
- therapies that may re-traumatise: i.e. non-evidenced based modalities
- not including family/carers in the process where appropriate and approved by the person
- having to re-tell their story on multiple occasions
- multiple contact points and inconsistency
- building up of and failure to meet expectations
- failure to believe and a lack of respect
- a lack of a timely response to contact
- limitation on time allowed for interventions
- minimisation of experiences

- concerns about confidentiality
- poor mental and physical health
- financial barriers, fees and charges
- literacy barriers
- geographical and logistical barriers, need to travel long distances
- failure of financial redress to acknowledge the seriousness of what has occurred
- failure of redress to include access to ongoing support
- unduly complicated and complex systems and red tape,
- when contact is treated as a 'complaint' and follows a very legalistic process
- support services which lack transparency and consistency
- services which do not ask the victim and survivors what they need or want and how they want to receive support
- services led by assumptions based on what the worker thinks the victim or survivor need, and
- treatment approaches which are not underpinned by a trauma-informed practice

48 Support services must ensure that their processes, policies and guidelines do not make the assumption that victims and survivors are unwell or need to recover.

1.3 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?

Public Campaigns

49 Effective campaigns are needed to counter perceptions which:

- blame victims
- diminish the responsibility of perpetrators
- perpetuate re-victimisation
- suggest children are most often abused by strangers (the majority are abused by someone they know)
- suggest that perpetrators are predominantly paedophiles (which suggests CSA is a form of sexual deviance which it is, but it is primarily an abuse of power), and
- focuses attention on a 'kind of person' rather than kinds of behaviour, such as entrapment, grooming and control of children and the production and consumption of child pornography.

50 Public campaigns should be comprehensive and:

- be developed in consultation with survivors and survivor groups
- invite the community, but particularly men to take a stance against abuse, and
- raise the profile of the complex and varied experiences of abuse of male survivors and female survivors.

51 The advocacy and support and/or therapeutic treatment services that are effective for those affected by CSA are those that are provided with respect and compassion and address their practical, day-to-day needs. Elements of these services would include:

- encouraging people to talk to someone they trust in the first instance
- awareness campaigns that urge those affected by CSA to seek support
- specialised support services that are staffed by caseworkers with a deep understanding of the complex issues victims and survivors are facing
- specialised support services that are funded for advocacy, referral and therapeutic services with an understanding that therapeutic help may be required longer-term rather than shorter term
- person-centred therapy, enabling the person to lead their own recovery
- therapies that include a focus on emotional and physical wellbeing as a means to recovery
- a timely response with no waiting lists
- flexibility in communication and the ability for support to be accessed at a location close to the victim or survivor that minimises the need to travel
- careful assessment and matching of victims and survivors to appropriate counsellors
- trauma-informed services
- cultural competence, and
- a clear division between support services and claim investigation and compensation processes.

52 Many people do not present to support services with sexual abuse as the lead or even stated issue. Instead they present for a range of reasons such as family breakdown, homelessness, addiction or mental health problems. Depending on experience, people affected by abuse may also have suffered discrimination and complex disadvantage. People affected by CSA need to be treated with patience, understanding, respect and compassion and to be offered practical assistance.

53 In turn, support services need to be flexible, evidence-based, accessible, and culturally and gender appropriate. People affected by abuse need to be assessed and matched to appropriate services, but must remain free to choose the support services they attend.

54 Most individuals seek support from a support service in times of crisis – just before, during or immediately after disclosure. The needs of survivors vary:

- Some individuals remain in regular frequent contact for many years.

- Some may contact their support provider on an irregular basis, especially if they feel that they are doing well. The need for contact may be as simple as the need for reassurance that the support is still there, if needed.
- Others may discontinue contact after a particular, stressful process, eg criminal court or achieving the settlement of a claim for damages.
- Persons affected by abuse or their family members have made contact with support services some years after the last contact when other life challenges have triggered some acute distress or emotional crisis.

55 Consistency and stability of personnel working in a support service is an important factor in being able to support individuals 'reconnecting' with the service as and when they feel it necessary.

56 There remains a significant level of undeserved shame, guilt and embarrassment surrounding CSA. When a person first contacts a support provider they often choose to meet in a neutral setting. Individuals may have kept their abuse secret from their families.

57 The idea of disclosing their abuse requires significant courage and meeting with others or joining a group at that stage may be unacceptable to them. It is important that support services are encouraging and supportive but also accepting of the individual's pace and their readiness.

58 Individuals need to be ready and feeling comfortable with how widely they share their story as well as when and where they do so.

> 'Henry' presented to a Diocesan support service some years ago with a history of CSA. Initially he did not feel comfortable attending the service's offices and so meetings were usually held in discreet coffee shops. Henry was adamant that he did not want to be invited to any gatherings, meetings or anything that may identify him as a victim of abuse.
>
> Over time Henry became open to meeting with a few other men who shared similar past histories and, in more recent times, has been happy to attend public meetings and to share his story on the radio and in the newspaper where he was happy to be identified.

59 Given the average delay in disclosing CSA, a large proportion of the people accessing support are mature-aged. Consequently, it is advantageous to have support services that reach out and are able to visit people in their local area as opposed to requiring individuals in need to travel to the service locations. Alternatively, individuals may need assistance such as transport or financial assistance to access more formal support such as counselling appointments.

60 For many individuals, having their experiences of CSA validated by the institution in which the abuse occurred is vital in shifting feelings of responsibility and shame. For others the church has been an integral part of their life and they want to maintain some connection. For those who have become alienated from their church community, being part of a network or group can assist in partly compensating for their lost community.

61 Equally for some, accepting support from a part of the institution that has been responsible for a person's abuse is unacceptable. In these circumstances support services that are Church-provided need to be able to make facilitated referrals and payment of counselling without having personal contact with the individual. In other words, support services need to be able to facilitate support for survivors in either category.

62 Support services should recognise the importance of not being housed in a building that is reminiscent of or near to the site of abuse. Former presbyteries or overtly 'Catholic' buildings are inappropriate and require the support service to identify alternate facilities.

Arranging Counselling

63 Support services should offer supported and targeted referrals to psychologists, counsellors and specialist social workers who are registered with a professional body.

64 Support services might also facilitate other evidence-based approaches like yoga, mindfulness, group therapy and retreats in addition to individual counselling.

Facilitating Groups and Connections

65 Support services should also facilitate group work and networking with others.

66 Support groups can be aimed at particular issues, such as small groups for those directly affected by abuse, post-trial groups and groups for people brought together in the wake of inquiries such as the Royal Commission or the recent Special Commission of Inquiry in NSW.

67 The therapeutic value of group work is equally important for those supporting a person who was abused. Support groups for supporters of those who have been affected by CSA can be valuable. In this context, presentations on topics such as mindfulness, resilience, vicarious trauma, taking care of one self and spirituality can be provided. In the experience of Church support services, feedback from attendees is constantly positive.

Practical Assistance

68 To provide an effective holistic support service, it is imperative that the service offers support to those indirectly affected including parents, siblings, children and partners. CSA has a ripple effect that can last for many years and affect those close to the individual who was abused. Disclosing abuse may provide some sense of relief for the person who suffered the abuse, but it may also initiate a crisis for other family members and loved ones who had previously been unaware of their loved one's personal trauma.

69 Other family members and loved ones may require assistance in dealing with their own reactions, learning strategies to cope. Assisting family members and other supporters often means increasing their capacities and further enabling them to continue to provide support to those directly affected, which consequently enhances their recovery. This support may include facilitation of counselling, linking people into groups or one on one interaction with someone from a similar situation.

70 Support services should offer practical assistance to individuals affected by CSA and their family members.

71 Incapacity to maintain steady employment often produces financial hardship. Support services need the ability to arrange for provision of financial assistance for household bills from Church, government and non-government agencies to assist payment of bills. At other times support services might advocate on behalf of family members for assistance which will help them support a person who has been abused.

> 'Betty' approached a support service for financial assistance after her adult son who had suffered CSA returned to live with her and her husband following a break up with his partner. The diocesan support service arranged for the diocese to fund the building of a separate bathroom to facilitate Betty's son living at home.

72 Examples of the sorts of needs that support services should assist with for individuals who have experienced CSA might include the arrangement and payment for mental health assessments to assist treating medical practitioners to prescribe medication, or to assist their Centrelink claims for disability pension. Support services might also assist individuals by writing letters and statements of support, for example to family and criminal courts.

> 'Kevin', a middle aged man who was affected by CSA, was charged by police for assault.
>
> The assault was related to Kevin retaliating against a man who upset his daughter by pulling her by the arm.
>
> Kevin asked his support service to write a letter of support for court, which provided his history of his CSA, explained the framework of his mental health state at the time of the assault and explained that Kevin's reaction was related to his "over protectiveness", an effect of his abuse.
>
> The charges against Kevin were dismissed.

Support during Court Proceedings

73 Support services are best placed to offer individuals support for those pursuing their rights for justice. Diocesan support services in NSW have received a number of referrals from police, usually shortly after the individual has reported their abuse, so that the support service may be involved from the beginning to the end of the criminal justice process, from investigation to sentencing of a perpetrator (if a guilty verdict is given).

> 'Andrew', a man in his early 30s, presented to a diocesan support service with his dad some years ago to disclose that he had been sexually abused by a teacher at his Catholic primary school when he was approximately 10 years of age. Andrew had never told anyone and initially was not sure that he wanted to report the matter to the police – he just wanted to make sure that it didn't happen to anyone else.
>
> The matter was reported to the police by the support service, but Andrew knew it was still up to him as to whether he made a statement or not. The support

> service facilitated a meeting between the relevant Detective and Andrew to explain the process of making a statement.
>
> Andrew eventually made a statement and was supported at the time by his support worker. The support worker also supported Andrew at court when he gave evidence at the trial and read his Impact Statement on his behalf at the abuser's sentencing hearing. Following the court process Andrew was introduced to some other men who had also experienced CSA and the court process.

Acknowledgement of the impact of abuse on Spirituality

74 Some victim survivors want to reconnect with their spirituality and may benefit from contact with an independent spiritual adviser.

> 'Pauline', who was affected by her sibling's history of CSA by a member of the clergy, could not bring herself to attend a mass or step into any religious premises.
>
> However, she found she missed the spiritual connection she once had as a child through her active involvement with the church. She also had fond memories of a nun who was very kind to her when she was a child.
>
> She requested assistance from her support service, which facilitated her attendance at a spiritual retreat run by nuns.

Symbolic Gestures

75 On occasion, Diocesan support services receive requests to undertake particular actions which have special symbolic significance to an individual affected by abuse. Such requests might relate to giving away or ceremonially burning something that the offender gave them as a child (eg a prayer book or rosary beads), or burning the collection of documents or media articles the person may have collected about their abuser.

> 'Phillip' was abused as a young boy by a teacher 'Doug' who was also his cricket coach.
>
> When Phillip approached the support service, Doug was deceased but not long after his disclosure more people came forward reporting abuse by Doug.
>
> Doug had his photo hanging in the local Catholic High School because of his success as a cricket coach and Phillip requested that this be removed.
>
> There was also a sporting award given to the school's most promising cricket player that was named in honour of Doug.

> With the assistance of the local parish and school, the support service arranged for the photo to be removed and the award to be renamed.

Access counselling/psychological/psychiatric and medical services

76 There are barriers to funding and access by victims and survivors to appropriate counselling, psychological, psychiatric and medical services, including:

- Victim and survivors may have limited resources to access therapeutic support services.
- Mental Health Care plans under Medicare only provide for ten sessions per year with a gap payment required.
- Private psychiatric services can be difficult to access with a referral required by a treating GP and a costly gap payment.
- Ongoing medication can be costly.

77 There are noted benefits of utilising legal support to advocate for victim and survivors needs. A number of victims and survivors disclose a reluctance to engage in accessing services of support without legal assistance. However legal support requires the financial means and can reduce the therapeutic benefit of engaging with support services.

Victims and survivors as a whole person with individualised needs

78 It is important to note that the medical model cannot and does not meet all of a victim and survivors needs. All the different areas of a victim and survivors life can be impacted in various ways by the abuse and trauma they have suffered. How it impacts on one person may be very different to another. Therefore, support services should respond to collaboratively with victims and survivors to ensure each victim and survivor's individual needs are captured holistically.

> A key strength of a co-ordinated approach is the capacity to fund the medical components such as counselling, psychiatric support and medication and make links to other supports which may fall out with the intrinsic medical model.
>
> A model of care including a 'care coordinator' has been helpful to victims and survivors by providing them with a single point of contact. The therapeutic relationship between the care coordinator and victim is of vital importance to build trust and confidence and ensure care is responsive to their needs.
>
> The care coordinator can:
>
> - provide information on available treatment
> - facilitate access to treatment and services outside the medical model (via

contact and funding)

- provide referrals to appropriately experienced and qualified therapists
- payment of associated costs
- review and coordinated service delivery, facilitating a continuum of care
- a case planning service with agreed goals

Fragmented care

79 It is best practice that treating professionals involved in the care of a victim or survivor have dialogue with one another to assist in formulating treatment plans and ensuring care is complementary to one another. Best practice regarding treatment reviews and reports suggests ongoing contact between treating professionals and care co-ordinators, via care plan meetings with other treating professionals can be beneficial in ensuring victims and survivors avoid fragmentation in their care.

80 In the absence of regular reviews and collaboration, fragmented, unintegrated care risks re-traumatising victims and survivors and is unhelpful in the recovery process. Further, there may be other supports the care co-ordinator can offer, however it is difficult to provide informed advice to treating professionals without a treatment plan and progress reports. There may be a number of reasons for this:

- Lack of understanding about purpose of requests for treatment reviews and plans
- Beliefs around the care co-ordination service and its funding by the institution responsible for the abuse and/or past negative experience in engaging with institutionally funded support services
- The victim or survivor requests that no contact occur
- Lack of time by treating professional
- Lack of experience in undertaking treatment plans and providing reviews
- Belief that the treatment plan will be subject to scrutiny or criticism by the care co-ordinator
- Concerns around confidentiality of reports and intended audience.

Access to Information

81 Lack of accessible information around what supports are available leads to re-traumatising as a result of:

- victims/survivors being unable to access supports
- confusion and frustration which may lead to abandonment of pursuing support
- anger towards institutions for failing to provide this information in a clear accessible way
- distrust and suspicion around supports due to lack of clarity and transparency

- victims/survivors resorting to using legal avenues to obtain funding for treatment from institutions. This can be stressful, lengthy, and costly
- victims/survivors may view the lack of information as a failure by institutions to acknowledge abuse.

82 To address these issues service providers need to have clear information available, stating their role, values and guiding principles, services provided and contact information, both for the service and other providers. Policies regarding confidentiality, decision making appeal and feedback processes should also be clear and easily accessible.

1.4 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?

83 Many of the issues discussed at 1.1 above are equally valid for secondary victims.

84 The impact of abuse on secondary victims is often underestimated or overlooked. These needs should be attended to holistically. Where appropriate it is important to ask about the welfare of husbands, wives, children, parents, siblings etc.

85 An effective holistic support service offers support to those indirectly affected by CSA, including parents, siblings, children and partners. CSA has a ripple effect that can last for many years and affect those close to the individual who was abused.

86 Other family members and loved ones may require assistance in dealing with their own reactions, learning strategies to cope. Assisting family members and other supporters often means increasing their capacities and further enabling them to continue to provide support to those directly affected, which consequently enhances their recovery. This support may include facilitation of counselling, linking people into groups or one on one interaction with someone from a similar situation.

Topic B: Diverse victims and survivors

2.1 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?

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?

Gender, cultural differences

87 Research has shown that men and women who survive abuse may be affected in ways that are gender specific, as discussed earlier.

88 Additionally research shows clinicians need to be aware of cross-cultural issues in adults surviving CSA. A person's culture influences their values and coping style. Culture can impact on how victims and survivors manage the effects of CSA, how their disclosure is received and responded to and how they are treated as survivors. This is particularly important if a clinician is working with a survivor with a different cultural background from their own.

89 Diversity among people affected by CSA needs to be acknowledged in the design and provision of support services. A range of models and approaches need to be available to provide support for people affected by CSA who come from diverse backgrounds.

90 People of indigenous and specific ethnic backgrounds can be very hesitant about reporting any issues of sexual or emotional abuse for fear of what may happen to them.

91 A case management model is needed that puts in place experienced culturally appropriate case workers, or expertise working in disability services, who can help victims and survivors access interpreters and culturally appropriate services.

92 For example, when working with people from a CALD background, support services might consider working with a migrant and refugee settlement service to provide appropriate services.

> The Western Australian Professional Standards Office (WA PSO) works extensively with Aboriginal people affected by abuse in Catholic missions and hostels, and with care leavers, particularly former child migrants from the UK and Malta.
>
> The WA PSO works closely with Tuart Place, a support organisation started by care leavers for care leavers. The governing body of Tuart Place commissioned extensive research to inform the service that included a large-scale survey sent to former child migrants.

> The model is one that provides a broad range of services including counselling, support groups, life skills, computer skills, family tracing, support with complaints, obtaining records and social activities.

93 Advocacy and support services within the Church that cater to the specific needs of diverse victim and survivor groups include:

- the Daydawn Advocacy Centre in the Archdiocese of Perth that promotes the rights of the individual and the full participation of the indigenous population in society
- the Emmanuel Centre that is a mental health self-help support centre
- Identitywa which provides support for people with disability and their families.

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

94 People leaving correctional settings can be particularly disadvantaged in terms of personal, family, community and financial resources to access and maintain engagement with services.

95 Central to the successful transition to the community is a relationship with a support service and key worker that is established before release to ensure ongoing contact and support.

Prison settings

96 Prisoners (inclusive of victims and survivors) within prison are prioritised for treatment based on:

- Length of sentence
- Nature of offence
- Risk of re-offending
- Available treatment within prison.

97 The very experience of being institutionalised within an environment which may not be dissimilar to the setting in which the abuse occurred, may act as a triggering point for victims and survivors. Victims and survivors may find themselves hyper vigilant around both prison officers and other prisoners.

98 Access to individualised treatment supports is impacted by resourcing constraints and the priority focus of reducing risk of re-offending. Victim and survivor's confidentiality would be an issue in designing programs and services within a prison setting.

99 The individual needs of victims and survivors within prison settings could be met by:

- specific one-on-one therapeutic programs
- skilled counsellors, and
- practical resources such as available rooms.

Community Corrections in Victoria

There are barriers are faced by victims and survivors who are subject to a community based dispositions or parole orders. Whilst offenders are referred to programs designed to reduce re-offending, these are not specifically designed to provide treatment for those suffering trauma.

In Victoria, the Community Correctional Officer (CCO) or Specialist Case Manager (SCM) is guided by the framework embedded into the Corrections Victoria Deputy Commissioner's Instructions. The CCO is a case management role with a dual purpose; monitoring and supervision, combined with a therapeutic element. CCOs are not counsellors. Rather, they refer to offenders to other services to provide this support.

In some cases, during ongoing case collaboration, offenders may disclose that they are a victim of sexual abuse. In such cases, they may be referred for some trauma related treatment under a Medicare funded Mental Health Care Plan. However, this is limited to ten sessions per year, which may not be sufficient time to provide a therapeutic outcome.

Carelink has worked with victims and survivors who have been subject to both prison sentences and community based dispositions. Carelink offers a coordinated service delivery, with care team meetings facilitated by the care coordinator, involving the victim, CCO, treating psychologist and relevant government department representatives. A treatment plan is discussed with agreed goals and strategies collaboratively agreed upon.

Topic C: Geographic considerations

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

What would help victims and survivors outside metropolitan areas?

Are there innovative ways to address the geographical barriers to providing and receiving support?

100 Challenges for support providers working outside metropolitan areas include distance, cultural sensitivities, a lack of reliable communication and other technologies.

101 Victims/survivors residing in regional areas may have limited access to:

- private therapists experienced in supporting complex trauma presentations
- mental health services
- medical services
- information services
- other community supports such as educational, vocational and other services.

102 For victims/survivors residing interstate and overseas additional challenges can arise including:

- increased isolation due to limited resources and services
- a need for financial support to help with access to appropriate communication and technology
- increased travel and accommodation costs with an associated need for financial support to help
- a reluctantance to engage with support services over the phone or through the internet. It can be challenging to develop a working, trusting, therapeutic relationship without having met face to face
- time zone issues
- international banking delays for payment of invoices and services for overseas
- varying avenues to access medical services, national health services and health insurance schemes that may be unique to their country of residence

103 A lack of access to crisis care services in remote and regional Australia is a particular concern.

104 Services also need to be resourced and prepared to send staff to survivors for face-to-face contact and support when necessary.

> The Diocese of Cairns covers territory from Cardwell in the south, to the Torres Strait, and west to the Gulf of Carpentaria. It is difficult to resource support for people impacted by sexual abuse across the area of the Diocese.
>
> The Diocese has addressed this by arranging for upskilling of its personnel already working within communities in the area of community support, responding to victims and survivors, to ensure that support services can respond appropriately to the needs of people on the ground.

105 When survivors and victims have moved away from the location where the abuse occurred, contact is usually maintained via electronic media (phone calls, texts and emails). On occasion, support services are able to travel to meet with people outside their area of primary operation, to support them through particular processes. They also sometimes arrange for the survivor to travel to them for face-to-face therapy, including for example group work.

106 Groups like the Young and Well Cooperative Research Centre (CRC), which explores the role of technology in young people's lives, and how those technologies can be used to improve the mental health and wellbeing of people aged 12 to 25, are doing a lot in this area. An example is *Stayin' on Track* which aims to transition young Aboriginal men to fatherhood through a user-developed website and use of a smartphone app *Mood Tracker*.

> 'Bernard', a man in his late 70s, was called upon to give evidence at a Royal Commission's Public Hearing in Queensland. Bernard was abused in Queensland from the age of 10 to 14 but now lives in Newcastle.
>
> The opportunity to tell his story meant a lot to Bernard. However, Bernard suffers from severe anxiety, spends most of his time at home alone and avoids social contact.
>
> At the time he was asked to give evidence before the Royal Commission he had been working with a support case worker for almost two years. He asked the Royal Commission if the worker could support him during the public hearing.
>
> The Royal Commission funded the case worker's accommodation and travel.
>
> The support service was with Bernard, managing media inquiries, supporting him while giving evidence, debriefing, sharing meals and generally assisting Bernard to travel to and from Queensland.

107 The Jesuit Social Services Support after Suicide program has formed an on line community with 550 members across Australia (https://community.supportaftersuicide.org.au/). The on line community provides information, enables confidential discussion and mutual support, and is moderated by Support After Suicide counsellors who can make contact with anyone perceived as experiencing difficulty.

108 Carelink has pointed to the need for a national resource list of trauma informed and experienced counsellors and therapists including those located in regional/rural areas. Services should also look to provide a variety of mediums to enable contact with the service, including by telephone, face to face meetings, email and skype/face time.

Topic D: Service system issues

4.1 There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of CSA.

Are the current terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?

1 The Council accepts the working definitions of terms presented in the Issues Paper, noting however that some Church agencies tend not to use the term 'victim or survivor' unless the person refers to themselves in that way.

2 Some people do not like to be identified as a 'victim' or a 'survivor' or to be defined by what has happened to them. As one person said *'healing is a journey, a process, not an event'.*

3 Healing and Support in the Diocese of Maitland-Newcastle uses the term 'those affected by CSA, directly, or indirectly' which is usually shortened by 'those affected by abuse'.

4 The Diocese of Parramatta has also changed the language from 'complaint' to 'record of experience'.

5 The Cairns Diocese suggests the term 'therapeutic treatment' be changed to something less clinical, like 'therapeutic recovery'.

4.2 Given the range of services victims and survivors might need and use, in what practical or structural ways can the services system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need?

6 A therapeutic case management model with experienced clinical practitioners (preferably social workers) who are not providing the therapy but assessing need and providing support will help ensure victims and survivors receive the coordinated services and care they need.

7 Therapists must be adequately trained, including in trauma-informed practice.

> The staff of Healing and Support in the Maitland-Newcastle Diocese are trained and follow *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (ASCA, 2012) and submit that personnel providing direct services to people affected by abuse should have appropriate tertiary qualifications, supervision appropriate for the seniority and experience of the staff member and experience in the application of ASCA practice guidelines or equivalent trauma informed practice.

8 Services should be individualised, flexible and coordinated and give victims and survivors control. The person seeking care must be believed and should be supported to maintain engagement with therapeutic intervention/s. Victims and survivors may need access to financial assistance, intense support through periods of heightened stress, and access to services on a needs basis, which may not always be at regular intervals.

9 Uncapped funding, with appropriate checks and balances, is needed to ensure the access and support outlined above. In a perfect world, requests for support would be evaluated on merit rather than existing capacity.

10 Such a model of service provision and funding is counter intuitive to bureaucratic structures and it may be that community agencies are better able to provide more flexible services in line with what has been outlined above.

4.3 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?

11 A nationally consistent approach provided by accredited professional bodies would ensure ongoing clinical supervision, training and professional development. Practitioners should be skilled members of a professional body.

Topic E: Evidence and promising practices

5.1 What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional CSA are emerging from practice-based evidence?

Where are these available and who can access them?

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

What other learnings are emerging from practice-based evidence or from grey literature (ie: published reports, and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?

1 There is no consistent collaborative body tasked with the development of practice standards for the support of adults who have suffered CSA. There are however some good practice guidelines, namely:

- Adults Surviving Child Abuse (2012), Practice Guidelines For Treatment Of Complex Trauma And Trauma Informed Care And Service Delivery
- Victorian Centres against Sexual Assault (CASA) Forum (2014)
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- National Association of Services Against Sexual Violence (NASASV), UNSW (2009) Framing Best Practice: National standards for the primary prevention of sexual assault through education
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2 Some important points to consider outlined in the above documents, in both services and therapy for survivors of ASCSA are:

- choice and options regarding services and support available
- believing and validating the survivors/victims experience
- reframing and reinterpretation of the abuse
- use of language which is non-judgmental
- affirming and encouraging the victim/survivors individual strengths
- understanding the contextual, cultural and universal aspects of sexual assault
- for the service delivery model to give central place to the rights of victims/survivors to be treated with dignity and respect

- empowerment of the client through providing choices, options and control over decision making and the counselling process
- recognising and responding to the diversity of victims' cultural and linguistic background, disability, sexual orientation, age and geographical location
- providing a safe place for the client
- communicating and sustaining hope and respect
- facilitating disclosure without overwhelming the client
- being familiar with a number of different therapeutic tools and models
- viewing symptoms as adaptations
- having a broad knowledge of trauma theory
- teaching clients adaptive coping strategies (eg self-care, distress tolerance strategies and arousal reduction strategies)
- teaching clients to monitor their thoughts and responses, and
- teaching clients interpersonal and assertiveness skills.

3 Support services need to be available to people affected by abuse in a manner and for as long as needed This 'open ended' support may be regular or irregular, with new contact at times being initiated by other life events. There should be no restraints or conditions placed on the level of support which is offered. A person's support should be managed by way of interagency collaboration and collegiate relationships with a range of other professionals.

> The Healing and Support team of Zimmerman Services in the Diocese of Maitland-Newcastle works with people who have been affected by CSA perpetrated by members of the diocese.
>
> There has been no formal evaluation of the efficacy of Healing and Support's model. However, there is strong, positive anecdotal feedback from the people with whom Healing and Support have worked.
>
> Further, key external authorities and institutions have consistently noted the positive effect for individuals who have taken up a referral to Healing and Support, notably NSW Police, NSW Office of the Director of Public Prosecutions and both the NSW Special Commission of Inquiry into matters relating to the Police investigation of certain CSAs allegations in the Catholic Diocese of Maitland-Newcastle and the Royal Commission into Institutional Responses to Child Sexual Abuse.

APPENDIX 1

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