Tuart Place
Growing Strong Together
24 High St., Fremantle WA 6160 Ph: 08 6140 2380 Freecall: 1800 619 795
Fax: 08 9382 4114 admin@tuartplace.org www.tuartplace.org

Government of Western Australia
Department for Child Protection
and Family Support
lotterywest supported

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

The Tuart Place submission on advocacy and support and therapeutic treatment services responds to Topic A: Victim and survivor needs and unmet needs, Questions (1), (2) and (4); and Topic E: Evidence and promising practices, Questions (2) and (3). The Introduction provides an outline of the Tuart Place model of support for survivors of child sexual abuse in institutional contexts. The submission concludes with a Summary of key points made in response to each of the Questions, and five Recommendations for action by the Royal Commission.

Introduction

About Tuart Place

Tuart Place is an innovative, participant[1]-led organisation for adults who have experienced any form of out-of-home care during childhood, including Forgotten Australians, former child migrants and the Stolen Generations (known collectively as 'care leavers'). Approximately 75 per cent of current participants at Tuart Place have disclosed experiences of institutional child sexual abuse.

The Tuart Place service includes a 'no wrong door', 'one stop shop' resource centre. Activities and services are provided free of charge and include: person-centred clinical and professional services, such as trauma-informed counselling, therapeutic support groups and psycho-educational workshops; individual and collective advocacy; life-skills and computer literacy classes; family tracing; supported access to records; assisted referral to mainstream services; support with abuse complaints processes; a biannual newsletter; and access to pro bono support such as visiting dental, genealogical and legal services.

Tuart Place also provides opportunities for participants to be involved in peer mentoring, leadership and mutual support. Participant-led activities include: social activities; outings; community awareness-raising initiatives; celebrations; reunions; regular luncheon meetings; fundraising; a newsletter; and participant-led classes to develop practical skills.

Organisational structure

Tuart Place is a fully incorporated, not-for-profit organisation and is a Public Benevolent Institution with Deductible Gift Recipient status.

The service is governed by the Board of Forgotten Australians Coming Together (FACT) Inc. and a Governance, Risk and Finance Subcommittee. The 10-member FACT Board is comprised of Australian-born care leavers and former child migrants, (Chair, Vice-Chair and three Ordinary Members), plus five professional members elected for their expertise and qualifications in areas such as law, accounting, service management and governance.

[1] During a process of consultation in 2012, a group of regular attendees at Tuart Place elected to be known as 'participants' rather than 'clients'. The term 'participant' is used to refer to care leavers who choose to be involved in activities at the Centre.

Tuart Place receives core funding from the WA Department for Child Protection and Family Support (DCPFS) and Lotterywest, as well as small grants from entities such as ConnectGroups WA and local government. Additional funds are actively sought and accepted on an unconditional donation basis from non-government past providers. Feedback from Tuart Place participants has been unequivocal on the issue of past provider funding, i.e. *past providers should pay for support services*, which is consistent with views expressed by the Royal Commission, and its finding that it is particularly important to some survivors that the elements of redress 'be funded by the institutions responsible for the abuse'.[2] So far Tuart Place has been successful in obtaining donations from the Christian Brothers, the Sisters of Mercy and the Sisters of Nazareth. To date, Tuart Place has not received any financial support from Federal Government programs such as Find & Connect or Royal Commission Support Service funding.

Tuart Place as a model of support

Statistics reported by the Royal Commission into Institutional Responses to Child Sexual Abuse indicate that 43.4 per cent of abuse cases disclosed by private session attendees in 2013–2015 occurred in out-of-home care settings.[3] Given the large proportion of care leavers in this cohort, and the successful outcomes reported by Tuart Place participants both anecdotally and in formal evaluations, it is apparent that the model of service developed by Tuart Place can help inform the planning of therapeutic support mechanisms for people who experienced childhood sexual abuse in out-of-home care.

Additionally, the Tuart Place model has proven effective in its support for survivors who experienced child sexual abuse in non-residential institutional settings, and many of the psychological sequelae associated with childhood sexual abuse are common to people abused in both non-residential and residential contexts. Both cohorts benefit from the approach to psychological support, advocacy and therapeutic treatment underpinning the Tuart Place service model. The impacts of child sexual abuse identified in the Royal Commission's report on Redress[4] apply to all survivors, although negative outcomes may be exacerbated if the victim was a child in out-of-home care.

Tuart Place frequently receives counselling referrals involving people who did not experience out-of-home care, most commonly former students. This reflects an increasing recognition of the specialist expertise among our clinical staff and visiting practitioners. These referrals are sometimes funded under the Medicare Better Access scheme. Referrals are also received from Royal Commission support workers, medical practitioners, lawyers, and professional standards entities accessing funds from past provider organisations.

TOPIC A: Victim and survivor needs and unmet needs

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

Survivors of childhood sexual abuse have varying needs and benefit from customised forms of support. If the spectrum of necessary support is seen as a continuum, at one end is situated a cohort of people who were abused in non-residential institutions, whose family and community connections remained intact, and whose educational path was not disrupted. This cohort is referred to as 'Group 1'. They may typically benefit from fairly straightforward psychological interventions provided in individual or group settings by trauma-informed practitioners.

[2] Royal Commission into Institutional Responses to Child Sexual Abuse (2015). *Redress and Civil Litigation Report*, Commonwealth of Australia, August 2015., p. 206.
[3] Ibid., p. 121.
[4] Ibid., pp. 176–180.

At the other end of the continuum is another cohort of survivors who were sexually abused in out-of-home care, whose family systems are non-existent or abusive, who always felt too 'different' to connect with a community, and who were denied an education or were too traumatised to learn. This cohort is referred to as 'Group 2'. They have more complex needs and benefit from specialised and holistic support mechanisms.

Survivors of child sexual abuse in institutional contexts: Spectrums of harm	
Group 1	***Group 2***
Abuse in non-residential institutional setting	Abuse in out-of-home care
Family relationships intact	Family systems non-existent or abusive
Community networks intact	Socially isolated, no community networks
Education not disrupted	Education unsatisfactory or too traumatised to learn
May require limited specialist support	Complex trauma requiring comprehensive specialist support

While it is recognised that the Royal Commission's Terms of Reference restrict it to inquiry into treatment modalities focusing on sexual abuse, evidence reported by the Commission to date indicates that, in Australia at least, a large proportion of survivors of institutional child sexual abuse were abused in out-of-home care. Case studies reported by the Royal Commission further suggest that Group 2 survivors may outnumber those in Group 1, for whom a more traditional (albeit specialist and trauma-informed) counselling service may be adequate. For this reason, it is important that treatment options recommended by the Royal Commission respond to the needs of survivors in both groups.

Psychological counselling

Evaluative data gathered by Tuart Place and anecdotal feedback from participants on the topic of counselling are consistent with all the Royal Commission's recommendations to date on counselling and psychological care.[5] In addition to the seven principles listed in the Commission's Report on Redress, we propose some additional elements of effective service delivery in this area:

- *Opportunities for establishment of trust.* A compromised capacity to trust is frequently linked to childhood sexual abuse and, while it is common to both groups mentioned above, it is likely to be exacerbated among Group 2 survivors, for whom an effective service delivery model would include opportunities for survivors to gain a sense of safety and confidence in the organisation prior to committing to any form of treatment, particularly counselling. It is also important that the counselling approach is trauma informed and relational rather than primarily cognitive/behavioural.

- *Non-bureaucratic service delivery.* Understandably, people who experienced childhood sexual abuse in an institutional context may be distrustful of bureaucracies and large organisations; it is, therefore, important that counselling is offered in a 'non-bureaucratic' setting, where the emphasis is on meeting the needs of the individual, not the organisational system.

- *Awareness of potential for cycle of abuse*. Psychological care should be provided by practitioners who have appropriate awareness of the potential for 'cycle of abuse' offending among survivors of child sexual abuse and the knowledge and capabilities to address this as a present-day child protection issue. This matter is discussed further in Topic E (3). It must

[5] Ibid., p. 196.

be emphasised, however, that only a small proportion of survivors of childhood sexual abuse later offend against children.

Psycho-social support and a holistic approach to treatment

The numerous and multi-faceted impacts of child sexual abuse are identified in the Commission's Report on Redress, which refers to harm caused at individual, interpersonal and societal levels.[6] The Commission has also noted the serious and often lifelong nature of these effects.[7]

Evidence gathered by the Commission on this matter contributes to a large body of existing knowledge in this area supporting the use of holistic and flexible treatment options. Tuart Place includes the following elements in an optimal service delivery model for survivors:

- a 'no wrong door', 'one stop shop' approach to service delivery that is client centred.
- involving survivors in the development and governance of services.
- highly skilled professional practitioners with competence in best practice therapeutic interventions.
- strategies to retain staff on a long-term basis, to facilitate continuity of interpersonal connection.
- psychological counselling that is trauma focused and informed by trauma expert Judith Herman's three stages of recovery: (1) establishing safety; (2) reconstructing the traumatic story; and (3) restoring the connection between the survivor and his/her community.[8]
- an emphasis on collaborative relationships and empowerment; Tuart Place operates from a 'non-dependency' perspective and encourages self-determination and self-actualisation.
- recognition that survivors *may* have very limited literacy skills, particularly those who experienced Group 2-type harm to their education (i.e. were too traumatised to absorb information in the classroom, or had disrupted/non-existent schooling). Survivors feel stigmatised by impaired literacy and can go to great lengths to conceal it. The optimal approach to service in this area does not assume that survivors are either literate or illiterate; it simply holds this as a possibility and proceeds with sensitivity and adaptability to either circumstance.
- the creation of opportunities for involvement in line with a Recovery Model. As noted in the report of an independent evaluation of Tuart Place conducted in 2014, the greatest opportunities for recovery and healing are found in places offering Safety, Connection, Opportunity and Hope to survivors.[9]
- opportunities for peer support and peer leadership (discussed below).
- service delivery that is flexible and responsive to differing needs. Staff are sensitive to potential underlying issues and individual levels of need. Outreach support is provided in some instances.

> *'Together we're building trust and what that means to me is that I can finally trust people to tell my story to and know that I'll be listened to and be believed. I feel that all of us here have built a great trust in one another and we don't feel different or alone anymore.'*

[6] Ibid., p. 178.
[7] Ibid., p. 179.
[8] Herman, J. (1998). *Trauma and Recovery*. Pandora, London, p. 155.
[9] Bailey, S. and School of Population Health, Social Work and Social Policy (2014). *Tuart Place: Providing support of substance for care leavers in Western Australia*. Faculty of Medicine, Dentistry and Health Sciences, University of Western Australia, Perth, p. 22. (http://www.tuartplace.org/index.php/evaluation-report, accessed 2-11-15)

Peer support

The benefits of peer leadership and group support models are acknowledged in a considerable amount of existing research evidence.[10] Both forms of interaction lead to greater social connectedness and enable therapeutic normalisation of symptoms commonly experienced by survivors of childhood abuse.

The Tuart Place model incorporates a range of participant-led activities that assist in breaking down social isolation, provide opportunities for people to make meaningful contributions, and encourage the development of supportive interpersonal relationships and networks.

Independent support networks are actively facilitated and encouraged to develop outside the organisation. Participants 'look out' for each other – visiting those who are ill and showing friendship to those who are isolated or lonely.

Advocacy

Advocacy is a key element of optimal service design for the support of survivors of institutional child sexual abuse, especially care leavers, and particularly those who suffered Group 2 spectrums of harm.

In addition to advocacy for individual survivors engaging with mainstream services such as housing, health and Centrelink, Tuart Place offers emotional and practical support to survivors engaging in restorative justice and professional standards processes with non-government past providers. This involves helping survivors to take as much control as possible over the process – for example, selecting a lawyer and deciding whether or not they wish to receive a direct personal response/apology and, if so, nominating who should be present and where any meetings take place. Survivors often identify Tuart Place as the preferred venue for meetings with professional standards workers and past provider representatives, because it is a familiar and non-bureaucratic setting. Considerable advocacy work has been, and continues to be, conducted on behalf of survivors to ensure that survivors achieve optimal outcomes from professional standards processes. A flow chart and guidelines for best practice in this area have been developed.

Advocacy involving non-government past provider organisations has changed somewhat since the commencement of the current Royal Commission, which has increased the volume of activity in this area. Various past provider organisations have asked Tuart Place to contribute knowledge and expertise to the development of more effective responses to victims of child sexual abuse in their

[10] See, for example: Hodges, J. and Markward, M. (2004). 'Effects of self-help service use upon mental health consumer satisfaction with professional mental health services', *Psychiatric Services,* Summer; Macauley, C. (2011). 'Peer Support and Trauma Recovery', *Journal of ERW and Mine Action, Issue 15*(1), Spring, 14–17; and Kaufmann, C.L., Ward-Colasante, C. and Farmer, J. (1993). 'Development and evaluation of drop-in centers operated by mental health consumers', *Hospital and Community Psychiatry, 44*, 675–678.

institutions. This line of communication with different past provider organisations creates ongoing opportunities for advocacy on behalf of survivors, at both individual and systemic levels.

Participant-led advocacy
At Tuart Place, participants are invited to assume as much control as possible over their own advocacy, and some participants and peer leaders have reached the stage where they now advocate on behalf of other individuals and on systemic issues affecting care leavers.

Five of the ten members of the FACT Inc. Board (the governing body of Tuart Place) are care leavers, including the Chairperson and Vice-Chairperson. Care leaver Board members play a pivotal role in systemic advocacy on behalf of their peers. For example, FACT Chairperson Ronald Love, an ex-resident of Castledare and Clontarf Boys' Homes, is involved in many forms of advocacy and awareness raising and is also a Committee Member of the National Alliance for Forgotten Australians (AFA). As FACT's Vice-Chairperson, Parkerville Children's Home ex-resident Jennifer Aldrick appeared at the Royal Commission's public hearing in March 2015 and advocated powerfully on the topic of redress for Forgotten Australians.

Other examples of participant-led advocacy include: annual presentations to student social workers at the University of WA; a participant-led campaign in 2012 disputing a federal funding decision; and a successful participant-led approach to the WA Ministry of Housing in regard to ex-gratia payments and State Housing eligibility.

The creation of opportunities for care leavers to take leading roles in advocacy, organisational governance and community education is a key element of optimal service design and is consistent with the 'Survivor mission' stage in Judith Herman's model of trauma recovery.[11] In this phase of recovery, the individual has reached the point in the healing process of wanting to help others and share what has been learned.

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

As noted in the Royal Commission's discussion of counselling and psychological care, survivors identify a number of unhelpful practices, such as time-limited therapy, short-term symptom-based interventions, and counsellors not letting clients take the lead.[12] Verbal evidence provided to the Commission highlights the importance of flexibility in the provision of psychological care:

> …Many survivors that we've met with have told us about other things that would be important for them, particular things like peer support, et cetera, so the whole definition of 'psychological care' should be – many survivors say, 'We've had enough counselling, we don't want it any more [sic]'.[13]

Inflexible delivery of counselling and psychological care
In our experience, many survivors, particularly older care leavers, do not want counselling. The expectation that survivors will want to engage in counselling can be viewed as condescending or patronising. Survivors may also be wary of counselling, or think they are 'too old' or 'too uneducated' to benefit from it. The issue of counselling needs to be approached with sensitivity and responsiveness to the client's stated wishes.

[11] Herman, J. (1992). *Trauma and Recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.
[12] Royal Commission into Institutional Responses to Child Sexual Abuse (2015). *Redress and Civil Litigation,* pp. 182–3.
[13] Ibid., p. 185.

Countless survivors have come to Tuart Place for an ostensibly 'non-therapeutic' purpose (for example, to access records or for a social event) and, once trust has been established, will engage in counselling. The process might not be called 'counselling' and, for example, might be referred to as 'preparation for a complaints process with the [past provider organisation] and debriefing after the meeting'. Similarly, psychological care of a survivor accessing personal records might be called 'catching up to have a chat about what came in the mail'. Optimal service delivery in this area will have this flexibility and will not be confined by rigid definitions of counselling and psychological care.

Pre-emptive disclosure of childhood trauma

Healing and recovery from childhood trauma and abuse is stage based, and survivors may experience harm if they are encouraged to 'reconstruct the traumatic story' before 'safety and stabilisation' have been established.[14]

In our experience, this problem is most commonly associated with engagement in redress-type processes. It has been noted among former Redress WA applicants and class action participants, care leavers giving evidence to previous Senate Inquiries, survivors telling their story to the Royal Commission, and people engaging in the various professional standards processes currently on offer.

It should be noted that counselling is/was available through many of these initiatives, and that many survivors refuse counselling. However, the 'telling of one's story' often, unfortunately, precedes the offer of counselling and the opportunity to establish safety and stabilisation.

As noted in the response to Topic E (3) in this submission, research evidence supports our clinical observations that re-traumatisation during a complaints/redress process can be associated with an increase in emotional dysfunction, relationship problems and offending behaviours, and may represent a child protection risk in some cases. For example, van der Kolk observes that 'Failure to approach trauma-related material very gradually leads to intensification of the affects and physiologic states related to the trauma, leading to increased repetitive phenomena'.[15]

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?

The response to this question describes Tuart Place's approach to the support of family members, which has been formulated over a period of years and continues to develop in response to needs identified in this area and the feedback of participants and their family members.

The overwhelming majority of respondents to a survey conducted by Tuart Place in February 2015 affirmed that family members of survivors should be able to access support services.[16] Several respondents said that problems arising from their childhood abuse and neglect had affected all members of their family. 'Counselling' was the most frequently identified form of support needed by family members.

Support of family members at Tuart Place

The most common forms of support provided by Tuart Place to family members are: counselling; psycho-education on the impacts of childhood trauma and abuse, including parenting problems;

[14] Herman, J. *op. cit.* p.189.

[15] van der Kolk, B. (1989). 'The Compulsion to Repeat the Trauma: Re-enactment, Re-victimization, and Masochism', *Psychiatric Clinics of North America*, Vol.12, No. 2, June 1989, pp. 389–411.

[16] Survey reported in the *Submission by Tuart Place on the Redress and Civil Litigation Consultation Paper by the Royal Commission into Institutional Responses to Child Sexual Abuse*. http://childabuseroyalcommission.gov.au/policy-and-research/redress/submissions-on-redress-and-civil-litigation/all-submissions, accessed 28-10-15.

assistance with family tracing and access to historical records and photos; and facilitating contact between the adult children of deceased care leavers and people who may have known them during childhood.

The disclosure of childhood sexual abuse
In our experience, survivors of child sexual abuse are often very reluctant to disclose the abuse to family members. Their reluctance may be underpinned by an effort to 'protect' the family from traumatic information, or a belief that such a disclosure might cause family members to 'look at them differently'. For male survivors, there may be a concern that they will be seen as potential child abusers themselves, while both men and women may fear being seen as 'damaged goods' or in some way to blame for the abuse.

Ironically, it is often very healing to the family system when spouses and adult children of survivors are finally included in 'the secret'. Obviously, there are exceptions, and sometimes disclosure is not advisable; however, family members can become far more forgiving of the survivor's past behaviour when they understand what happened to him or her as a child. In many instances, family members already sensed that 'something happened' to their loved one, often fearing it to be worse than the actual abuse (especially when it occurred in one of the more notorious former institutions). This kind of disclosure can provide relief to family members and break down barriers to closeness in family relationships. The adult daughter of a former child migrant, whose father finally told her about the physical and sexual violence he had experienced in a WA orphanage, wrote: '*All the anger I felt towards him is gone because now I understand why he treated us the way he did. I wish I had known years ago.*'

Tensions and challenges
Challenges can arise when family members and survivors seek support from the same agency. Care leavers in particular may feel ashamed that they were not a 'better' parent/spouse/sibling, and survivors can lack insight regarding difficulties in their family relationships. In the case of adult children of survivors, there may have been an intergenerational cycle of abuse.

As mentioned above, the main forms of support provided to family members of current participants at Tuart Place are counselling and psycho-education, and the care leaver generally remains the 'primary client'.

Family members – unless they were in care themselves – are not eligible to attend the therapeutic support groups currently operating at Tuart Place. If support groups for family members are developed, it may be useful to adopt the kind of model used by organisations such as Alcoholics Anonymous. A person with a drinking problem can go to AA meetings, while their family members are eligible to attend meetings of Al-Anon (an affiliated fellowship that offers a program of recovery for the families and friends of alcoholics).

Topic E: Evidence and promising practices

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

Tuart Place: A 'ground-breaking' model of service
Tuart Place is committed to ongoing evaluation and continuous improvement in response to feedback from participants and other interested parties. The report of an independent evaluation completed by the University of Western Australia (UWA) in 2014 validates and affirms the Tuart Place service model as one that is participant led and facilitates self-determination. The Evaluation Report states that 'Tuart Place is leading the way in providing an organisational response to the

needs of participants who were abused as children in institutions, using a restorative justice approach', [17] and that 'the governance model of Tuart Place is unique and ground breaking in social services delivery in Australia'.[18] The UWA evaluation of the Tuart Place service model and a *Presentation of Key Findings* are available on the Tuart Place website: http://www.tuartplace.org/index.php/evaluation-report

The development of Tuart Place's Key Principles and Service Model was informed by an extensive research and consultation process documented in a comprehensive Business Case commissioned by FACT Inc. in 2011 and funded by Lotterywest. A key source of information for the Business Case was a questionnaire, developed through a series of consultative workshops and focus groups, posted to 960 West Australian care leavers and completed by 222.

Support and ongoing assistance was provided by a reference group comprising the CEOs of major not-for-profit organisations in Western Australia, including Mercycare, Anglicare, UnitingcareWest, RUAH, ERCM and Lotterywest, all of whom recognised the importance of establishing a dedicated service for care leavers in WA and supported FACT's innovative approach to service design and delivery.

Subsequent research has included a second postal survey of service users in 2013 seeking feedback on developing areas of service delivery. The results of this survey were published in Issue 6 of *The Tuart Times* newsletter and showed that newsletters, information and announcements disseminated by Tuart Place were the most highly valued features of the service, closely followed by: help to locate personal records and photos; a homely and welcoming 'drop-in' environment; counselling and support groups; and help to navigate mainstream services.[19]

In addition to the external evaluation by researchers from UWA (in 2014), Tuart Place has conducted a series of internal evaluations of its innovative service model and programs. Qualitative data on improved outcomes for Tuart Place participants are reported six-monthly as part of FACT's contractual obligations to funders Lotterywest and DCPFS.

'Feedback Fortnight'
One of Tuart Place's internal evaluations – 'Feedback Fortnight' – was conducted over a two-week period in November 2014 and gathered qualitative data on any identified changes in participants' social, interpersonal and practical skills, and participant satisfaction with activities and services. Survey forms were submitted by 28 participants, with feedback being overwhelmingly positive.

The first set of questions related to how participants felt about themselves since using the Tuart Place services: did they feel more confident, more at ease, more able to communicate with others, more socially connected, more able to find/ask for support and more hopeful for the future. There was an average of over 94 per cent agreement with these statements, with comments including: 'I am learning'; 'I am more confident to express the things I am sure of, still need to work on other things and my belief in myself'; 'I am now able to talk about my experiences at Tuart'; 'Sometimes I do feel at ease but when I feel stressed I head back to Tuart Place for reassurance'; 'Have [hope] now – didn't before'; and 'For someone who didn't know how to read and write – not doing too bad.'

The second set of questions related to interaction with the staff. There was 100 per cent agreement that participants felt they were treated with respect and that staff were friendly/approachable/listened well and gave adequate information: 'Staff at Tuart Place always

[17] Bailey, S. and School of Population Health, Social Work and Social Policy (2014). *op. cit.* p. 4.
[18] Ibid., p. 28.
[19] *The Tuart Times*, Issue 6, September 2013, ISSN: 2204-7646, p. 5.
http://www.tuartplace.org/index.php/tuart-times , accessed 31-10-15.

treat me with respect and encourage me to be proactive'; 'Staff I feel value my input'; and 'Always friendly and approachable but get very busy'.

When asked what is the best thing about Tuart Place, 'Non-judgmental' was identified in one way or another by over one-third of respondents: 'feel safe'; 'no pressure'; 'accepting of everyone'; 'not judged'; 'non-aggressive environment'; 'freedom to speak or not'; and 'I feel I actually count for something'.

Two-thirds of respondents indicated that 'no changes' were required to the service when asked for changes and suggestions. Other suggestions included having more parking, opening more days and finding ways to 'get the word to other people about Tuart Place'.

All respondents (100 per cent) said that they would recommend the service to others and, in all cases, the comments were positive: 'I've told lots of people'; 'Not only recommend but bring others along'; 'For sure'; and 'Already have'.

FaCS Staff Exchange Program

Further evaluation opportunities have developed through a staff exchange program with the WA Department of Finance – Funding and Contracting Services (FaCS), which also provided an opportunity to present information about Forgotten Australians and Tuart Place to an audience of State Government Funding and Contracting Services personnel. FaCs staff members subsequently attended a full-day exchange at Tuart Place and returned in September 2015 to facilitate two focus groups with participants for the purpose of developing participant outcome measures for the service.

The 11 participants in the two half-day focus groups were all care leavers, 10 of whom had disclosed institutional child sexual abuse. These participants had all accessed three or more of the following Tuart Place services over a minimum of six months:

> Drop-in, social activities, trauma-informed counselling, advocacy (legal, financial, health, Centrelink), help with abuse complaints to past providers, family tracing, therapeutic support group, life-skills and/or computer literacy classes, personal development group sessions.

Focus group participants were asked three questions:

1. What is your favourite thing about Tuart Place?
2. Why? How does it make you feel?
3. What difference does it make to your life outside Tuart Place?

The most common themes in the responses to Question 1 related to the staff being available, friendly, genuine and helpful, and to the centre being non-institutional and non-appointment based for most services. Participants valued being able to attend the service sporadically, with no pressure, and having long-term support available.

Themes in the responses to Question 2 included increased confidence, feeling more at peace, greater sense of self-worth, and knowing 'it wasn't my fault'.

Themes in the responses to Question 3 related to increased confidence and skills to positively manage personal relationships and to participate socially in the broader community, and increased ability and confidence to recognise their needs and access appropriate support from individuals and from service providers in the community.

A Case Study Report prepared by FaCS staff after the Staff Exchange Program with Tuart Place states that:

> One of the most valuable elements of the Staff Exchange visit with Tuart Place was being able to meet, and listen to the individual stories of, the participants. It became very clear that despite the various difficulties and traumas participants had experienced during out-of-home care, Tuart Place ensures they have access not just to vital support services, but also an important community in which they feel safe and connected[20].

A respectful approach to evaluation

The overarching principle in Tuart Place's approach to evaluation is non-intrusiveness. Many care leavers in Western Australia – particularly former child migrants – have a longstanding aversion to 'being researched', and evaluations with this cohort must be approached sensitively. Other issues, such as impaired literacy, can create barriers to participation. All information gathered from participants by the UWA researchers was provided verbally, and Tuart Place has developed 'user friendly' feedback forms for its internal research. Participants are never pressured to take part in any evaluation. Over time, many participants have come to trust Tuart Place's approach to research and evaluation, and some previously reluctant participants now welcome the opportunity to 'have their say'.

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

The response to this question describes learnings emerging from practice-based observations by Tuart Place regarding 'cycle of abuse' child sex offending behaviours, with specific reference to stress factors that may increase the potential for offending and risks to child safety. These observations are discussed with reference to relevant research literature. It is important to note that these observations do not suggest that the majority of care leavers are predisposed to, or practise, abuse. Only a small proportion of survivors of childhood sexual abuse offend against children themselves. However, the statistics suggest that the connection should be explored.

A cycle of offending

Over a period of years, Tuart Place and its forerunner services became aware that their populations of male clients included a higher than average proportion of individuals who had been convicted of child sex offences. This observation is perhaps unsurprising, as a considerable volume of research has found that most child sex offenders were themselves sexually abused as children. A 1995 study by Hawkins and Briggs found that 94 per cent of a sample of Australian men who offended against children had been victims of child sexual abuse themselves.[21] Research by Glasser et al. found that:

> Among 747 males the risk of being a perpetrator was positively correlated with reported sexual abuse victim experiences … Having been a victim was a strong predictor of becoming a perpetrator, as was an index of parental loss in childhood … The data support the notion of a victim-to-victimiser cycle in a minority of male perpetrators but not among the female victims studied.[22]

Similarly, a study by Ogloff et al. of a sample of 2,759 Australian people who experienced child sexual abuse found that:

> [T]he majority of victims sexually abused during childhood do not perpetuate the cycle of violence by becoming an offender … However, relative to members of the general population, both male and

[20] Hughes, A. & Heise, P. (2015). *Case Study Report: Tuart Place*, Government of Western Australia, Department of Finance – Funding and Contracting Services, June 2015. p.9.

[21] Hawkins, R. and Briggs, F. (1995). 'Early childhood experiences of men sexually abused as children', *Children Australia*, Vol. 20, No. 2, pp. 18–23.

[22] Glasser, M., Kolvin, I., Campbell, D., Glasser, A., Leitch, I. and Farrelly, S. (2001). 'Cycle of child sexual abuse: links between being a victim and becoming a perpetrator', *British Journal of Psychiatry*, 179(6), p. 482.

> female [child sexual abuse] victims are at an increased risk for committing or experiencing a range of offences, in particular those of a sexual or violent nature.[23]

Ogloff's research found that 5 per cent (1 out of 20) of male child sexual abuse cases were subsequently convicted of a sexual offence, which was significantly greater than for males in a control group, of whom only 0.6 per cent (6 out of 1,000) were convicted of a sexual offence. Significantly, Ogloff found the difference to be even greater when considering boys who had been victimised at age 12 years and above, where 9.2 per cent (almost 1 in 10) were subsequently found to have been convicted of a sexual offence. This was significantly greater than the rate for male child sexual abuse cases who were abused when under the age of 12 years (2.9%).[24]

An Australian study of 2,759 people who experienced child sexual abuse found that almost one in ten males who had been victimised at age 12 years or older were subsequently found to have been convicted of a sexual offence (Ogloff et al. 2012).

Predictive factors

A summary review of research literature conducted by Tuart Place in 2014 identified the following predictive factors in the childhood history of sex offenders, many of which are factors present in the childhood histories of people who were abused in out-of-home care.

Predictive factors in the childhood history of sex offenders include:

- childhood sexual abuse
- parental abandonment during childhood
- peer-to-peer offending during childhood
- apprehension by child protective services
- unstable family background
- physical abuse/emotional abuse/neglect
- multiple abusers and multiple forms of abuse
- childhood behavioural problems and juvenile delinquency
- negative relationship with mother during childhood
- any long-term separation from parents prior to age 16
- poorer family support and family relations during childhood and less support from people outside the family.[25]

The abovementioned review of literature was prompted by increasing anecdotal evidence of spikes in offending behaviours that coincided with particular past events; for example, a 1997 class action by ex-residents of Christian Brothers' institutions, and the Redress WA scheme. The review examined stable and dynamic risk factors identified in adult recidivist child sex offenders, seeking to understand whether there may be a link between people revisiting memories of childhood sexual abuse and an increase in sexual offending against children.

[23] Ogloff, J., Cutajar, M. C., Mann, E. and Mullen, P (2012). 'Child sexual abuse and subsequent offending and victimisation: A 45 year follow-up study', *Trends & issues in crime and criminal justice* No.440, June 2012, Australian Institute of Criminology, Canberra, p. 1.

[24] Ibid.

[25] *References cited in the Tuart Place summary review of literature:* Cashmore & Shackel 2013; Dhawan & Marshall 1996; Hanson 2000; Hanson & Bussière 1998; Hanson & Harris 1998; Lambie et al. 2002; Lievore 2004; Loucks 2002; McGregor & Howells 1997; Pithers, Beal, Armstrong, & Petty, 1989; Pithers, Kashima, Cummings, Beal, & Buell, 1988; Starzyk & Marshall 2003; Witt & Schnieder 2005.

The literature review failed to identify any studies that had investigated a possible link between an increased level of child sex offending among survivors revisiting and disclosing memories of childhood sexual abuse for an externally prompted purpose. It appears that little or no research has been conducted in this area. However, the 13 'stable' (i.e. chronic) risk factors and nine 'dynamic' (i.e. situational) risk factors identified in existing literature are not uncommon attributes in the childhood histories of survivors of childhood sexual abuse in institutional contexts, particularly those who experienced Group 2 spectrums of abuse.

Stable risk factors identified in adult recidivist child sex offenders include:

- socioeconomic, educational and occupational marginalisation
- intimacy problems
- social skills deficits and general social problems
- illiteracy and unemployment
- criminal history and association with sex offenders
- psychiatric symptoms and emotional immaturity
- anger problems, low self-esteem and assertiveness deficits
- negative relationship with mother in adulthood
- physical disability
- low intelligence
- low victim empathy
- alcohol or other drug abuse
- single (never married).

Dynamic risk factors for recidivist sexual offenders include:

- life stress and personal distress
- alcohol/other drug abuse
- hostility and negative emotional states
- post-traumatic stress and deterioration in lifestyle stability
- financial problems and poor accommodation
- cognitive distortions
- emotional collapse
- social isolation and interpersonal conflict
- increased psychological symptoms just prior to offending.

A considerable proportion of survivors engaging in redress-type processes experience at least two of the dynamic risk factors listed above, and some survivors experience them all. Frequently identified symptoms include increased use of alcohol and prescription medications, increased anger problems, a worsening of PTSD symptoms, and relationship problems. These dynamic risk factors *are likely outcomes of participating in the process itself*, and it is extremely common for survivors to report distressing symptoms triggered by participation in a complaint or redress process.

These observations have clear implications for practitioners and support services working with male survivors of abuse in out-of-home care and, in particular, survivors participating in any process in which they are required to provide a detailed disclosure of their own childhood trauma and abuse for an externally prompted purpose.

Practitioners working with survivors should also be knowledgeable about the differences between fixated paedophiles and regressed offenders. There are different therapeutic implications and specific child protection risks for each cohort. For example, Parkinson observes that offenders often abuse children who were much the same age as they were when they were abused, thus replicating

their childhood experiences, but changing their role from that of victim to perpetrator.[26] Other scholars comment on the phenomenon of 'behavioural re-enactment' in offending behaviours, including van der Kolk, who points out that traumatised individuals fixated on the trauma may re-enact it in an attempt to assimilate the experience.[27] This area of knowledge has obvious implications for agencies providing services to older survivors as well as children and vulnerable young people leaving care.

The problem of stigma

Shedding light on the issue of a sexual abuse 'cycle of offending' is problematic because of its potential to stigmatise and further disadvantage a cohort of (primarily male) survivors who have already been harmed by childhood sexual abuse. Some male survivors say they have never told anyone about their abuse for fear they would be suspected of being a potential offender themselves. Men who have spent time in jail for non-sexual offences have reported that they feared fellow prisoners discovering that they had been sexually abused during childhood. This situation created difficulties for a number of men who were in prison during the Redress WA scheme.

Tuart Place has no wish to cause further disadvantage or distress to survivors, and it is important to note once again that only a small proportion of survivors of childhood sexual abuse offend against children themselves. In our experience, child sexual abuse is more likely to result in the adult survivor reporting an abhorrence of any form of child maltreatment, including sexual abuse. Sadly, many male survivors of child sexual abuse report difficulties in having any form of physical contact with children or grandchildren – that is, it feels safer not to show any physical affection to children rather than risking a perception of 'inappropriate' contact.

A fundamental strategy for child protection and the prevention of child sexual abuse

Despite the risk of further stigmatising survivors, Tuart Place's observations on the cycle of child sex offending are presented in this submission because they are of great concern. It is our view that this issue needs urgent attention from the Royal Commission. Providing treatment to people whose sexuality was distorted in childhood in a way that led to the development of a sexual attraction to children is a fundamental child protection measure that is largely overlooked.

One of very few community-based treatment options for offenders in Australia was provided by the former SafeCare Inc., which was defunded some years ago on the basis that 'State funds were better spent on victims than offenders'. This decision was short-sighted – it only takes one step of logic to realise that one of the most effective ways to reduce the risk of child sexual abuse and to prevent child sexual abuse would have to be the provision of treatment to offenders[28].

Summary

This submission on Issues Paper 10 provides a comprehensive description of effective support, advocacy and psychological care for survivors of institutional child sexual abuse.

The model of psychological care proposed by Tuart Place incorporates all the Royal Commission's recommendations to date on counselling and psychological care and expands on these in several key areas. Significant features include non-bureaucratic service delivery, opportunities for the development of trust prior to engagement in counselling, and awareness of the potential for cycle of abuse sexual offending.

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[26] Parkinson, P. (2003). *Sexual abuse and the Churches*, Aquila Press, Sydney, p. 149.

[27] van der Kolk, B. (1989). *op. cit.* pp. 389–411.

[28] Cant, R. & Penter, C. (2006). *Independent Evaluation of SafeCare Families Program by Social Systems and Evaluations contracted by Department for Community Development,* Department for Community Development, Perth. July 2006.

The elements of psycho-social support, advocacy and peer leadership described in this submission are equally important parts of the model proposed by Tuart Place.

In responding to the question of what does not work or makes things worse for survivors, Tuart Place has identified inflexible service delivery and definitions of 'psychological care', noting that care survivors may be ambivalent about the idea of 'going for counselling'. Pre-emptive disclosure of childhood trauma is also identified as problematic, and practitioners working in this area are encouraged to assist survivors to establish safety and stabilisation before they 'tell their story'.

The discussion of support for family members of survivors describes the main types of support provided to family members at Tuart Place and identifies some inherent tensions and challenges in working with family members of care leavers. If support groups for family members are developed, we suggest that it may be useful to adopt the kind of model used by organisations such as Alcoholics Anonymous, in which family members are eligible to attend Al-Anon (an affiliated fellowship that offers a program of recovery for the families and friends of alcoholics).

The model of counselling, psycho-social support and peer leadership identified in this submission is based on the highly effective and innovative model developed by Tuart Place, which was externally validated in an independent evaluation conducted by researchers from UWA in 2014. Our discussion of the evaluation highlights key findings from this comprehensive analysis of the Tuart Place service model and summarises feedback gathered in smaller scale internal evaluations. A longstanding aversion to research among sectors of the WA care leaver community is noted, and measures taken by Tuart Place to ameliorate this issue are described.

The final response provided in this submission describes learnings emerging from practice-based observations by Tuart Place regarding 'cycle of abuse' child sex offending behaviours, with specific reference to stress factors that may increase the potential for offending and risks to child safety. These observations are discussed with reference to relevant findings in published research literature. Our anecdotal and clinical observations over a period of years were found to be consistent with research evidence regarding the predictive and risk factors for men who have experienced child sexual abuse and the subsequent development of offending behaviours.

The issue of a cycle of sex offending is highly sensitive, and Tuart Place has no wish to stigmatise, or cause further disadvantage to, survivors. Our submission emphasises the fact that only a small percentage of survivors of child sexual abuse later offend against children themselves, and, in our experience, the most common outcome of childhood sexual abuse is an abhorrence of any type of child maltreatment.

Tuart Place's observations on the cycle of child sex offending shed light on a topic that is difficult to discuss, but is of great concern, and it is our view that this issue needs urgent attention from the Royal Commission. As noted in this submission, providing treatment to people whose sexuality was distorted in childhood in a way that led to the development of a sexual attraction to children is a fundamental child protection strategy that receives insufficient attention.

Finally, the discussion of a cycle of offending in this submission also highlights the need for practitioners working with survivors of child sexual abuse to not only be trauma informed, but also competent in assessing child protection risk factors relating to the cycle of sexual abuse and treatment modalities for offenders. Awareness of the other predictive factors is also very important, particularly for services working with survivors of child sexual abuse engaging in redress or professional standards processes and for services working with children and older survivors.

Recommendations

1. The Royal Commission should note that significant features of effective support provision to survivors of child sexual abuse include non-bureaucratic service delivery, opportunities for the development of trust prior to engagement in counselling, psycho-social support, advocacy and peer leadership.

2. The Royal Commission should promote improved support for family members of survivors. With regard to group support, an appropriate model might be that used by organisations such as Alcoholics Anonymous, in which family members are eligible to attend Al-Anon (an affiliated fellowship).

3. The Royal Commission should investigate the issue of potential child sex offending tendencies that may develop as a result of child sexual abuse in institutional contexts.

4. The Royal Commission should investigate the possible link between survivors engaging in processes that require them to revisit and disclose memories of their own childhood sexual abuse for an externally prompted purpose and an increase in psychological dysfunction, including increased likelihood of acting on any existing sexual attraction to children.

5. The Royal Commission should encourage past providers to donate, on an unconditional basis, to specialist support services for survivors of institutional child sexual abuse.

Report prepared by Dr Philippa White, Director of Tuart Place, on behalf of Tuart Place. 1-11-15.