South Australian Government Submission to
Issues Paper 10 – Advocacy and Support and Therapeutic Treatment Services

OVERVIEW

The South Australian Government welcomes the opportunity to make a submission to the Royal Commission Issues Paper 10 – Advocacy and Support and Therapeutic Treatment Services (the Issues Paper). The Issues Paper highlights the complexity of advocacy, support and therapeutic treatment needs of people who have experienced child sexual abuse.

This response has been prepared on the basis of clinical practice experience within South Australia. It has also been informed by professional and research literature, which is detailed in the bibliography.

Child sexual abuse can lead to the vulnerability of repeat victimisation and/or perpetration in adult life. Childhood sexual abuse may result in an increased vulnerability to being a victim of sexual assault and domestic violence in adulthood.

Whilst most people can and do survive child sexual abuse and lead successful lives, complex traumatisation as a consequence of childhood abuse often continues to affect many people throughout their lives.

This response includes input from agencies responsible for service delivery either directly or indirectly, in particular Families SA within the Department of Education and Child Development (DECD), and SA Health, as described below.

State Government Inquiries: Commission of Inquiry into Children in State Care and Inquiry into Children on APY Lands

In 2004, the Parliament of South Australia enacted legislation to establish a Commission of Inquiry into Children in State Care. A separate inquiry was later established into Children on APY Lands.

Commissioner E. Mullighan Q.C. presented the reports of the Children in State Care Commission of Inquiry and Children on APY Lands Commission of Inquiry to the South Australian Government on 31 March 2008 and the 30 April 2008. The two Inquiry reports and the Government responses can be found at: https://www.sa.gov.au/topics/crime-justice-and-the-law/mullighan-inquiry.

Both reports made several recommendations the majority of which were implemented by the South Australian Government.

Families SA

Families SA is part of the Department for Education and Child Development.

Its primary area of concern is the protection of children. Within this context Families SA works in the following areas:

- Protecting children from abuse and harm
- Supporting families to reduce risk to children
- Providing alternative care for children and young people when home is no longer an option
- Working with young people who break the law
- Managing adoption processes
- Caring for refugee children at risk
- Delivering services to address poverty
- Helping communities affected by disaster to rebuild
- Families SA is committed to reconciliation and providing culturally appropriate services.

Families SA provides services through a network of 3 regions and 18 district centres and associated branch offices. Families SA programs and associated outcomes are:

- **Child Protection** - Children and young people are safe within their family and cultural environment.
- **Alternative Care and Adoptions** - Children, young people and families who have experienced harm are assisted to recover, be safe and nurtured to reach their potential.
- **Adoptions** - Managing adoption processes by assisting people who are giving up a child for adoption, are in the process of adopting a child, or were adopted in the past.
- **Corporate Services -** We have the workforce, management and systems capacity and capability to manage effectively and efficiently.
- **Dame Roma Mitchell Grants** - financial assistance to young people who are, or have been under guardianship of the Minister in South Australia.

Families SA Psychological Services provides psychological assessments, interventions, and consultation and training services for Families SA. Clinical psychologists are employed to provide a state-wide service to Families SA clients.

HEALTH LEGISLATIVE, POLICY AND SERVICE CONTEXT IN SOUTH AUSTRALIA

Legislative Context

The *Mental Health Act 2009* makes provision for the treatment, care and rehabilitation of persons with mental illness with the goal of bringing about their recovery as far as is possible. The Act confers powers to make orders for community treatment, or inpatient treatment, of such persons where required. It also provides for the protection of the freedom and legal rights of mentally ill persons.

Clinical treatment, advocacy and support services provided by SA Health mental health services and non-government (NGO) mental health organisations funded by SA Health are required to provide advocacy, support and therapeutic treatment services for victims and

survivors of child sexual abuse where that person is a consumer as part of their mental health treatment, care and support plan.

Health Service Delivery Context in South Australia

Victims and survivors of child sexual abuse may access a range of health services. Health services include both public and private health service providers as well as non-government service providers (NGOs) – many of the latter are funded by the State or Commonwealth Governments or both. The Medicare Benefits Schedule (Medicare), supported by the Pharmaceutical Benefits Scheme (PBS), provides universal access to the Medicare eligible persons to both public and private health services (general practitioner (GP), specialist, pathology and differential capped access to medications depending on income source).

Enhanced access to mental health therapeutic treatment services may be provided through Medicare funded services to private providers such as GPs, psychiatrists and also psychologists for which Medicare benefits are available for a range of specified psychology services for people with certain conditions i.e. where a person has an assessed mental illness and referred by a GP, a psychiatrist or a paediatrician. The national NGO providers of acute services which are funded by the Commonwealth Government may also receive funding from other State/Territory Governments. Victims and survivors of child sexual abuse experience vulnerability over their life and often require access to emergency telephone counselling services.

South Australian Health System

SA Health has a range of public hospital and mental health services for children and adolescents, adults and older people in South Australia which are delivered through the following Local Health Networks: Central Adelaide Local Health Network (CALHN, Women's and Children's Health Network (WCHN), Southern Adelaide Local Health Network (SALHN), Northern Adelaide Local Health Network (NALHN) and Country Health SA Local Health Network (CHSALHN).

Both general and mental health services are provided through community mental health centres and hospitals, and to consumers in their own homes. GPs can make referrals to specialist mental health services and public hospitals. State mental health services make determinations of whether a person will be admitted or referred to community care for treatment and support.

State Government partnerships with the NGO sector expand the capacity within the public mental health system to provide more services to people in need of assistance. Services include:

- Individual Psychosocial Rehabilitation and Support Services (IPRSS) – a partnership program providing one-on-one rehabilitation and support services in a person's home and local community.
- Psychosocial rehabilitation day and group programs – a variety of programs aimed at increasing self-management, interpersonal, recreational and daily living skills.

- Mutual support and self-help programs – consumer driven programs for sharing experience and to encourage people to work with others to attain improved mental health.
- Employment and pre-vocational support services – a partnership program to assist consumers with training and entering paid employment.
- Carer support and respite services – a variety of services such as support groups, education, counselling and advocacy aimed at assisting a carer of a person with mental illness.

State-wide Role of Women's and Children's Health Network (WCHN)

The WCHN is a state-wide service providing primary, secondary and tertiary health services primarily to children, young people and women from the ante-natal period across the life span. Divisions and Services of the WCHN include, but are not limited to:

- Child Protection Services (CPS)
- Child and Family Health Service (CaFHS)
- Yarrow Place Rape and Sexual Assault Service
- Multi Agency Protection Service (MAPS) – women's safety
- Metropolitan Youth Health (MY Health)
- Women's Health Service (WHS)
- Child Adolescent Mental Health Services (CAMHS)
- Division of Paediatric Medicine
- Division of Surgical Services
- Women's and Babies Division.

More information on these services is included at Appendix 1.

RESPONSES TO ISSUES PAPER QUESTIONS

Topic A: Victim and survivor needs and unmet needs

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

Not every person's experience of child sexual abuse is the same. Many factors including the age of the child, relationship of a perpetrator to the child, type of sexual abuse, duration of abuse, responses to disclosures and other experiences of trauma, which also intersect with cultural and social factors all contribute to the physical and mental health impact on the child.

Safety

Therapeutic interventions strive to support people who have experienced childhood sexual abuse to develop a sense of safety in the world. This sense of safety is essential to healing and long term quality of life. Safety must be reinforced by the institutions that people who have experienced child sexual abuse interact with, including hospitals and health care settings.

Collaboration

Children and young people who have extensive and complex trauma histories will benefit from interventions that are trauma informed and where all care providers (guardians, health, education, child protection) work collaboratively utilising a therapeutic care team approach. Most people who have been traumatised seek to avoid triggers or reminders of the trauma – actively seeking therapy to work through the trauma can be very difficult. Assertive engagement and robust trust building strategies are useful, particularly with adolescents who may desperately need support but are understandably resistant to engaging.

Accessibility

Accessible services are also essential. People will access therapeutic services often when their discomfort levels are very high and they are in a lot of emotional pain. Their pain management strategies may no longer be working and may be desperate for relief. This is the window of opportunity for the counsellor, therapist or helper to engage with the person. Waiting lists do not work for traumatised people. Access to 24 hour phone/online crisis services that are trauma informed, understand the neurobiology of sexual assault trauma, cater to children, youth and adults, are staffed by professionals who can support people until they are able to be access ongoing therapy is essential, for example 1800RESPECT which operates to support adults experiencing domestic violence and sexual assault, and Lifeline which offers general crisis support.

Therapeutic Interventions

There are a range of effective evidence based cognitive behavioural therapy (CBT) trauma models. Unfortunately many of these models require client stability and safety before intervention can begin, which isn't always possible for people who have experienced child sexual abuse. Therapeutic trauma models should be able to respond to clients who live in chaos or in a constant state of emergency. Many therapeutic trauma models have a strong focus on the establishment of safety and require a stable, safe environment in order to deal with trauma memories. For many children, youth and adults, the trauma events have led to instability and a lack of safety, yet therapeutic intervention is desperately required. There are a number of trauma intervention models emerging which work with 'chaos' and with comorbidity so the therapist is not left waiting for an' ideal time' or 'environment' in order to start a healing intervention.

Child sexual abuse impacts on a person's perception of safety - how safe they feel in the world - therefore trust is an issue for many who have experienced child sexual abuse. Therapeutic interventions that are session-limited or phase-specific may be of limited benefit for this client group as they do not always allow for the complexity associated with trust building. People may also 'dip in' and 'dip out' of trauma therapy; models of intervention and services need to be flexible.

Trauma therapy is complex work and there is always the risk of doing further harm when working with traumatic memory therefore therapists should be trained, highly skilled and not work in isolation.

This is considered a complex area of clinical practice (see for example: Etherington K. (1995) *Adult Male Survivors of Childhood Sexual Abuse* which deals with one area of clinical practice). At the centre of any therapeutic intervention, a therapeutic relationship of trust is paramount as is continuity of care. Effective therapies include a range of psychological therapies such as Dialectical Behaviour Therapy (DBT), mindfulness approaches and Acceptance and Commitment Therapy (ACT), among others.

Psychosocial therapies are aimed at socialisation to decrease isolation and to develop community connections. Life skills training and support, self-esteem, family support, vocational rehabilitation are all essential areas of support necessary for improving quality of life. Occupational therapy helps to enable people to participate in the activities of everyday life, to work with people and communities to enhance a person's ability to engage in these activities (see for example Finlay L (2004) *The Practice of Psychosocial Occupational Therapy*).

Expressive and creative therapies such as music and art therapy can also be used to assist people with trauma histories. These therapies often promote a sense of safety, create an opportunity to begin to enjoy things as well as providing a space where trust and rapport can be established, especially for those who find talking therapies too difficult or confronting. For example, music therapy can provide opportunities for experiencing choice and control, social support and experiences of joy, meaning and purpose. Expressive therapies (such as music therapy) can provide empowering experiences to re-establish a positive identity, to process traumatic memories, release anger and affirm values and aspirations. Music can be used

therapeutically in learning coping strategies to manage stress and anxiety and emotional arousal.

Tailored programs to address issues pertaining to PTSD and shame may be required. The fundamental principles when meeting with victims and survivors of child sexual abuse are timeliness, sensitivity, confidentiality, a safe respectful believing environment to disclose, development of a shared understanding and reassurance that the hurtful actions of others are not their fault. By far the most important provision is to validate their experience and reactions. Victims and survivors benefit from a consistent therapist.

Child sexual abuse victims have stated that it is hard to talk about the abuse and once they start it is hard to stop talking about it. Victims and survivors of child sex abuse desire more than anything else that someone will believe them and they want to trust someone with this information and in turn not be judged. Talking about the abuse for some can be therapeutic and liberating but for others, the traumatisation can often be continued.

In State mental health services, if a consumer reveals a history of child sexual abuse, clinicians may refer the consumer to a psychologist for ongoing therapy. Additionally, supportive group sessions or a referral via the GP for a Mental Health Care Plan or a referral, if acceptable, to more specialist services for counselling such as Respond SA or to a support line may be offered. Respond SA provides information and resources for people who have been affected by childhood sexual abuse, including adult survivors, friends, family, and professionals working in the community services sector.

Trauma informed care (TIC) can play a crucial role for survivors of child sexual abuse wherever they interact with a health service without the need for disclosure and can result in providing high quality, consistent health care which prioritises the safety and wellbeing of women, men and children.

Therapeutic intervention for child sexual abuse is optimal when children, youth and adults are in safe and stable environments and have access to trauma informed supportive and responsive health systems. A trauma informed care system or organisation will assist in creating a safe environment.

It is also unhelpful to expect or require a person to deal with issues when they do not have the resources to cope, but at the same time, people should be supported to access services in the future should they wish to. Appropriate therapy starts with a focus on staying safe, using coping strategies, reducing arousal, and establishing supporting social/family networks before there is any attempt to integrate trauma memories.

The most harmful thing for victims and survivors is when they are not taken seriously and/or their experience abuse is not believed, or it is trivialised. For many victims and survivors, their story is that they have not been believed by a person in authority – parent(s), a family member or another responsible adult. The issue of trust remains paramount. Trust has been broken in the past so they need to be certain that they will be believed; that their story receives the acceptance by those in authority. One of the most important services victims and survivors can be offered is the opportunity to share information, express emotions and to be believed.

Child protection experience suggests that victims and survivors need a safe and supportive environment in which they feel safe to talk about their experiences, and to have staff and caregivers who understand and identify the warning signs that a child or young person has experienced sexual abuse. Best practice is staff and caregivers working with children and young people in the child protection system are educated regarding the nature and impacts of sexual abuse and therapeutic responses to children and young people who have experienced sexual abuse. In creating an environment in which children feel safe to disclose their experiences, the importance of the continuity of staff and caregivers, and their relationships with children and young people cannot be overemphasised. This is essential to assist victims to feel safe to disclose their experiences, and to feel supported and receive adequate services after disclosure.

In terms of advocacy and support, first and foremost, victims of sexual abuse need acknowledgment and validation of their experiences. The psychological literature is clear that outcomes for victims of childhood sexual abuse are mediated by the response of those around them (for example, caregivers, support people, services). Disclosing experiences of sexual abuse is incredibly difficult for victims and it takes a huge amount of courage to do so. This is best supported when disclosures are met with a calm, non-judgmental, accepting and empathic response and staff and caregivers working with children and young people in an educational, institutional or therapeutic setting receive adequate training and supervision to respond supportively to disclosures of sexual abuse.

There are various ways in which children disclose sexual abuse and many factors that inhibit children from doing so. These include embarrassment; worry that they will not be believed; fear of getting themselves or others (at times including the perpetrator) in to trouble; and worry about the involvement of police or child protection services. At times, significant emphasis is placed on the credibility of the victim's disclosure when intervening to secure their safety or seeking therapeutic support. Given victims often do not make clear verbal disclosures of sexual abuse (particularly at the time of abuse), there is a risk some children and young people will remain at continued risk of sexual abuse. Victim and survivor needs are best met when staff and caregivers understand and notice the possible early warning signs of sexual abuse and can initiate appropriate, but non leading, conversations with children and young people to ensure that the responsibility is not always left to the child to initiate disclosure.

The process of disclosure of sexual abuse is highly complex and unique to each child and their developmental stage. Furthermore, some of the emotional and behavioural indicators of sexual abuse are also characteristic of other forms of abuse. This can be confusing for staff and caregivers working with children and young people. It is not uncommon for young people to make disclosures of sexual abuse, only to later retract the disclosure. This can lead others to question the validity of the original disclosure and then question future disclosures. This can result in victims being left unsupported or viewed with suspicion. The psychological literature also suggests that children may delay disclosure for quite some time, sometimes into adulthood. Victim needs are best met when staff working with children or young people in an institutional setting or with survivors of abuse have sufficient knowledge

about the process by which victims disclose sexual abuse to ensure victims receive a supportive response.

Some of the ways in which children disclose or alert others they have been sexually abused are:

- Direct verbal statements;
- Less direct/ambiguous messages such as suddenly refusing to attend the house of a previously loved caregiver, not wanting to sleep alone or being scared of the dark;
- Non-verbal acts such as writing, drawing or role-playing;
- Demonstrating bodily or physical signs such as bruising or cuts from physical abuse, injury/discomfort in the genital region, sexually transmitted infections or urinary tract infections;
- Demonstrating emotional signs such as significant changes in mood or behaviour, withdrawal from school or social networks, self-harm, suicidal behaviour, disordered eating, or aggression;
- Exhibiting developmentally inappropriate sexualised knowledge and/or behaviour.

Victims of sexual abuse perpetrated in institutional settings are vulnerable, disempowered, and are often experiencing a multitude of comorbid psychosocial issues. They require a high level of advocacy and support to navigate the complex mental health and legal systems. The consistency of the supports is critical to ensure that victims are not required to tell their story to a host of different individuals. Furthermore, many of the victims in institutional settings struggle to trust others, particularly adults (often for good reason). Therefore, the quality, consistency and stability of their relationships with their available supports are essential.

The consistency of the services working with clients in a therapeutic context is also essential. This has been clearly identified in the psychological literature as essential to therapeutic progress. This is critically important to victims in an institutional setting who have often experienced relationships which have been harmful, frightening, and/or unstable. Families SA recognise the importance of the client having access to a consistent therapist and to this end there is no limit on the number of sessions which can be provided by both internal and contracted psychologists. To this end the therapist can continue to work with the client for an extended number of sessions, where ongoing therapy is clinically assessed as necessary.

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?

Continuity of care and easy access to services is important. Identifying individual's needs through assessment processes and treatment plans in care co-ordination by mental health services facilitates identifying needs and access to services. Important strategies in this area include:

- Presenting relevant issues at multi-disciplinary team clinical reviews and future care planning (not just addressing the immediate clinical presentation or symptoms)

- Care planning that is multidisciplinary and holistic in nature.
- Dealing with barriers, such as inconsistent clinical responses to a history of sexual abuse and related trauma. Other barriers are inconsistent organisational response to vulnerable people with a history of institutional abuse who are receiving a service within a clinical setting (such as an acute mental health unit) and receiving treatment which in the circumstances may lead to re-traumatisation.
- Ensuring flexible service approaches to address the individual needs of vulnerable people.
- Programs and services that address boundary violations and establish appropriate information/education/self-management strategies which are supported in organisational context, responding to observed boundary violation in reactions to consumers.
- Ensuring early therapeutic intervention services for children who have been abused. Working with children early is important, but ensuring the child remains safe especially if the abuse has taken place within their family.

Victims and survivors benefit from a quiet, calm environment in which to disclose. Experienced staff are important in enabling consumers to generate sufficient trust to disclose. Tailored services may increase the therapeutic benefits which arise from treatment. Barriers can include poor knowledge of available services and a lack of streamlined pathways to dedicated services.

Child protection experience suggests the following assists in seeking support:

- Victims and survivors require timely and empathetic therapeutic support in response to their disclosure. Services are best provided when the client feels ready to work through their experiences.
- Victims and survivors benefit from clear information about services which are available and relevant to them; what the services entail so they can make an informed decision about what service best suits them; and practical support (such as transport) to access services.
- Seeking therapeutic support can be overwhelming for anyone and there is often a stigma associated with attending therapy. Furthermore, therapy itself is challenging and can bring about the arousal of more painful memories and feelings. Clients benefit from having access to ongoing support from someone who acknowledges their experiences and can be a safe, stable and consistent emotional support for them whilst they progress through therapy. For children and families who are clients of Families SA, the Case Manager makes referrals to and facilitates access to support services.
- Victims of abuse, including abuse perpetrated in institutional settings, can be disempowered for many reasons: their age, intellectual disability, social isolation, mental health issues, substance abuse, poor financial status or all of the above. Clients need therapeutic treatment services that are flexible and can tailor their approach to meet the needs of this diverse client group. They also need therapists who are suitably skilled in working with clients who have experienced sexual abuse and are able to adapt their approach to individual client needs. Clients also need flexibility in the number of sessions they can access. It can take many sessions to

develop sufficient therapeutic rapport to discuss experiences of sexual abuse, therefore more than the standard 6-10 sessions (which are covered by Medicare, noting that Medicare will, under certain circumstances, provide funding for a limited number of additional sessions if needed) may be necessary and clients may need to be able to re-access therapy services in the future. Families SA psychologists (both internal and external contracted) have flexibility to provide ongoing therapeutic services for as long as clinically necessary.

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?

Secondary victims associated with the victims and survivors are considered an integral part of their journeys and with the consumer's permission, they can be invited to participate in meetings as part of the support system. However, most mainstream public mental health services focus on meeting the needs of the consumer.

From a child protection perspective, an important secondary victim group are the children of victims. The distressing impact of abuse on a parent may be expressed in a range of difficulties such as mental health issues, substance abuse, domestic violence and offending (including child sexual offending), which in turn may impact on parenting capacity. There are no dedicated services which primarily focus on secondary victims. Therapeutic services that primarily and directly target and prevent intergenerational trauma and transmission of abuse could be of benefit to both survivors and their children.

Topic B: Diverse victims and survivors

1. What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups? What types of models and approaches are used to address the particular needs of these populations?

Service co-ordination models include the Family Safety Framework or the Multi-Agency Protection Service (MAPS) where domestic violence is an issue. Referrals may be made to other services. Diverse victim and survivor groups may require a more selective and sensitive approach which is considered in assessments and included in treatment and care plans.

The following NGOs are known to provide advocacy and support services to clients in South Australia:

- Victim Support Service
- Anglicare SA
- Centacare
- Australian Refugee Association
- Migrant Resource Centre of South Australia
- Multicultural Youth Advocacy Network
- Multicultural Youth South Australia Inc.

Victim Support Service, Anglicare SA and Centacare offer services to general population, but also have developed frameworks for engaging specifically with Aboriginal and CALD (Culturally and Linguistically Diverse) clients. Migrant Resource Centre of South Australia provides specific advocacy and support service to migrants. Multicultural Youth Advocacy Network and Multicultural Youth South Australia Inc. similarly provide a specific service to migrant population, but with a focus on supporting clients in the 'youth' age bracket.

In terms of specific therapeutic services, the following agencies are known to provide services to clients from the diverse victim and survivor group in South Australia:

- Yarrow Place – provides a service to clients over 16 years of age
- Child Protection Services – provides a service to clients 2-12 years of age
- Child and Adolescent Mental Health Service – provides a service for children and their caregivers
- ACT for Kids – provides a service for children and their caregivers
- National Sexual Assault, Domestic Family Violence Counselling Service – provides a telephone and online services which can be good for adolescent and young adult clients
- Relationships Australia – provides a service to children, youth and adults
- Nunkuwarrin Yunti of South Australia Inc – provides a service to children, youth and adults

The first six of these services provide a service for the general population, but have expertise and a developed protocol for engaging specifically with Aboriginal and CALD clients. Nunkuwarrin Yunti of South Australia Inc provides a therapeutic service specifically

for Aboriginal clients. Aside from these seven services, Families SA Psychological Services provides a therapeutic service for children under guardianship (0-18 years of age) and their caregivers, including children who have been victims of sexual abuse. Adult victims and survivors of sexual abuse who have a diagnosed mental health disorder can also access psychological therapy via the Medicare system which will provide them with up to 10 sessions per calendar year (or 12 to 18 sessions if part of an Access to Allied Psychological Services program) with a psychologist in private practice or adult mental health services.

Lastly, Mental Health in Multicultural Australia has developed a comprehensive framework for professionals engaging with CALD clients in the mental health context and this framework can be very useful in considering specific therapeutic services for CALD clients who have been victims and survivors of sexual abuse.

2. How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?

The following features are recognised as helpful for victims and survivors from diverse backgrounds:

- Culturally competent responses to Aboriginal and Torres Strait Island people and other cross cultural groups.
- Service models and workforce planning that can respond to clients from different backgrounds including Aboriginal and Torres Strait Island people, people with disabilities (intellectual and physical disabilities), people from culturally and linguistic backgrounds and Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) communities.
- A service planning approach that enables tailored programs and services for these groups.

Based on child protection experience, the biggest impediment for clients from diverse backgrounds in obtaining advocacy and support and/or therapy service is not necessarily a lack of or inadequate presence of services, but rather clients' awareness and ease of access of services. Greater coordination and a central point of contact for clients may greatly enhance their ability to access services, rather than clients having to approach each service independently (thus dealing with widely different referral pathways and trying to compare quite different services).

An important initiative in this regard was the development of Families SA's Psychological Services of a Therapy Service Framework. The overall aim was to ensure that the mental health needs of children under guardianship are not only appropriately identified but are also properly addressed via access to a well-integrated and centrally coordinated therapy service. The Framework has helped to inform a more recent initiative, the establishment of the Interagency Therapeutic Pathways Panel, which is currently being piloted by Child and Adolescent Mental Health Services and Families SA.

Topic C: Geographic considerations

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

The challenges faced by service providers include:

- Providing access to confidential services and maintaining safety. For example, there can be risks regarding confidentiality in locally run programs.
- The geographic limitations of face-to-face encounters with staff which can assist in forming the trust and confidence for engagement, disclosure in the therapeutic journey; and
- Designing appropriate program and funding models for rural and remote areas e.g. The previously mentioned APY Lands project.

Families SA Psychological Services provides some therapeutic treatment, advocacy and support for victims and survivors who are under the guardianship of the Minister across South Australia (including in regional, rural and remote areas) through our internal service and panel of external private providers. The internal component of Families SA Psychological Service is based within the metropolitan area, with psychologists providing services to clients in regional, rural and remote areas by travelling to those areas and, in future, through the use of technology such as tele-and video-conferencing. The external panel of private providers utilised by Families SA Psychological Services consists of clinicians who reside in a range of locations, including some regional areas. They provide services to clients residing in their local area.

Whilst there are some shared challenges experienced by the internal and external components of Families SA Psychological Service in responding to the needs of victims and survivors living outside of metropolitan areas, there are additionally challenges which are unique to each component.

Practical challenges experienced by Families SA Psychological Services can include the following:

- Travel time can reduce the number of clients Families SA Psychological Services can cater for and can also increase costs for the client.
- Challenges in responding to emergencies, where a clinician is based a significant distance from the client.
- Challenges in providing therapeutic treatment via technology (such as through videoconferencing, telephone and email). Families SA Psychological Services has recently obtained appropriate videoconferencing equipment and is in the process of incorporating the use of this into the provision of therapeutic treatment.

Challenges experienced in relation to the external private provider component of Families SA Psychological Services include:

- recruitment of appropriately qualified and experienced clinicians who reside in regional, rural and remote areas;
- responding to emergencies, particularly when the clinician is based a significant distance from the client;
- accessing adequate technology (such as videoconferencing equipment) to provide services from regional centres to more rural or remote locations; and
- for clinicians who reside within a regional, rural or remote location, particularly in very small communities, there can be some challenges associated with providing a service to members of the community known personally to the clinicians (such as confidentiality challenges and clients' willingness to seek their service).

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

Innovations to overcome geographic barriers include:

- Internet-based and phone-based services for face-to-face service delivery. There have been applications developed for mental health service delivery to support consumers and maintain ongoing contact that could provide useful models for development for victims and survivors of child sexual abuse.
- Outreach in country or remote areas if and when specific specialist knowledge is needed.
- Service models that support regular visits and consistency in staff members.
- Service models that support outreach from metropolitan-based service providers by visiting clinicians.

Strategies which will address the geographical barriers to service provision to victims and survivors under the guardianship of the Minister include:

- The increase in service provision through alternative communication options, such as videoconferencing. Technology is becoming more widely utilised to address the geographical barriers of providing services from Adelaide or regional centres to more rural or remote locations. A literature base is developing regarding the provision of therapeutic treatment by such means.
- Families SA Psychological Services is currently trialling the use of videoconferencing technology in the provision of therapeutic services. In addition, there is a focus on increasing the number of clinicians based in regional areas who are on the external private provider panel.

Topic D: Service system issues

1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?

In the main, the terms are considered adequate. Families SA offers the following comments about specific terminology (below):

1.1 ***"Advocacy and support*** *is acting alongside, or on behalf of, victims and survivors of child sexual abuse 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. We also include systemic advocacy, advocating for changes to the systems designed to prevent and respond to child sexual abuse, including advocating for changes to services so victims' and survivors' needs are met."*

The above definition is predominantly concentrated on the notion of "advocacy," rather than broad support services. In general, advocacy is assertive and active in nature, whereas support could be passive. The above definition could be more accurately described as "support via advocacy" or "advocacy support".

It is important to recognise advocacy support also includes empowering the individual through increasing their personal knowledge of support services, their rights, and their symptoms (psycho-education). Advocacy can also involve keeping services accountable and ensuring that they provide an ethical and timely service. In addition to housing, health and welfare services, a further service area an individual may require support to navigate is disability services. Sexual abuse victims with disabilities may require supplementary advocacy and service supports to engage with services due to physical and/or intellectual disability. Victims and survivors can also benefit from advocacy support to access legal services to assist them with potential criminal proceedings and/or compensation claims. Finally, while the above definition acknowledges the differences between individual and systemic advocacy, this may be more effectively elucidated through separate paragraphs and a more comprehensive explanation of systemic advocacy.

1.2 ***"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 as 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."

In general this is an appropriate and comprehensive definition. It is quite broad, however it encapsulates the wide variety of therapeutic treatment service options.

The final sentence (*Therapeutic treatment aims to reduce symptoms of ill-health and bring about measurable change in outcomes that improve wellbeing and quality of life*) is unclear in its generalisation. The majority of the above definition focuses on mental health and psychological well-being; however the final sentence uses the term "ill-health" which could reference physical illness. Further, treatment aims to reduce symptomatology, increase resiliency, and increase positive and adaptive coping strategies.

2. Given the range of services victims and survivors might need and use, what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need? What type of service models help victims and survivors to receive the support they need?

The following types and features of service models are recognised as helpful:

- Models which provide tailored service programs.
- Models which promote knowledge of available resources and services within the community and professional groups.
- Streamlined referral pathways to dedicated services.
- Models which help to address stigmatisation. De-stigmatisation of the experience of and shame associated with child sexual abuse is considered and essential part of the beginning of the healing process. The campaign carried out by *beyondblue* and the Australian Broadcasting Corporation's "Mental As" during Mental Health Week is a significant initiative and enables the community to become more aware of the issues and facilitates wider discussion. Victims and survivors can be more likely to engage in a conversation with a range of services and receive support if they see that the issue is being de-stigmatised.
- Psychosocial models of care that complement symptom management in order to improve daily life functioning and quality of life.
- Holistic service models which encompass areas such as education, employment, independent living, coping skills and self-management.

There is support for the efficacy of early intervention models, and the provision of consistent and child focused supports. It may also be beneficial for services to be community based, and assist the individual as well as the family group/support network around them. Service models which endeavour to provide equitable access to services and monitor quality assurance would assist in understanding if victims and survivors are receiving the support they need.

In providing therapeutic services in a child protection context, education for carers regarding the therapeutic needs of abused children and therapy processes is considered helpful. Work is underway in South Australia to address this for children under guardianship of the Minister though the establishment of an Interagency Therapeutic Pathways Panel.

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?

Options to upskill practitioners and staff include:

- The provision of baseline training to all clinicians with advanced training for clinicians who are more involved with this population.
- Examining options to support select mental health staff to increase expertise which can be drawn upon by other clinicians.
- Increasing the delivery of specific therapeutic approaches within the curriculum of medical and allied health education student courses.
- Options for specialised education at both graduate and post graduate levels as well as ongoing professional development.
- Peer support and education.
- Psychosocial rehabilitation is a core aspect of the scope of practice of allied health clinicians (i.e. social work, psychology and occupational therapy) therefore allied health can be well positioned to provide these services if included in service delivery models.

In order to ensure that practitioners and staff are sufficiently skilled to provide services to victims and survivors they must have both an understanding of the dynamics, context, and complexities of sexual abuse, as well as access to supervision, debriefing, and professional development. In particular, practitioners and staff need:

- to have appropriate qualifications;
- to undertake tasks they are appropriately skilled to perform;
- to engage in self-reflection, including client engagement, and demonstrate an awareness of their strengths and weaknesses; and
- to access to cultural consultants and interpreters, when appropriate.
- clear guidelines regarding the frequency, policies and structure of supervision;
- regular supervision from a supervisor who has relevant qualifications and relevant clinical experience;
- to attending professional development opportunities to further develop (and maintain) their knowledge and skills; and
  to access to support for their own wellbeing to ensure staff can continue to work effectively with clients, given they may experience vicarious trauma.

In terms of advocacy and support, most Families SA case managers are social workers. The only exception is case work support officers, who operate in guardianship teams and receive supervision. In terms of therapeutic services, all staff are either psychologists or highly experienced social workers. Job and person specifications seek to select for these qualities.

Topic E: Evidence and promising practices

1. What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional child sexual abuse are emerging from practice-based evidence? Where are these available and who can access them?

This issue would be best answered by a panel of clinical academic and practising service providers. The following information gives some indication of the type of areas that may be providing promising therapeutic interventions.

For example, Southern Mental Health, through a doctoral study, is trialling compassion focussed therapy as an adjunct to cognitive behaviour therapy for people presenting to the Centre for Anxiety and Related Disorders at the Flinders Medical Centre. The study focusses on the impact of childhood sexual abuse and neglect on the ability to recover from anxiety and depression using CBT. The addition of compassion focussed therapy of 10 sessions is being tested in a randomised controlled trial. This study may provide additional insight into the type of therapies which may be more supportive and useful for victims and survivors of child sexual abuse.

Other studies have shown sensory modulation, domestic violence frameworks, trauma informed care models and music and art therapy programs are important along with programs which address PTSD.

A preliminary review of the literature has revealed no information regarding promising and innovative practices for victims and survivors of institutional child sexual abuse specifically. Therapies, interventions and modalities for child and adult victims and survivors of child sexual abuse include:

- **Cognitive Processing Therapy**

  There is evidence Cognitive Processing Therapy (CPT) has positive benefits for victims and survivors of child sexual abuse. It is a variation of Prolonged Exposure Therapy and CBT, but is effective with and without its exposure component. CPT focuses on memory activation and emotional reprocessing, addresses abuse-related cognitive distortions and encourages victims and survivors to feel their emotions.

- **Dialectical Behaviour Therapy**

  Dialectical Behaviour Therapy (DBT) is based on the cognitive behavioural framework and helps victims and survivors of child sexual abuse to find the middle ground between accepting who they are as well as recognising the need to change current maladaptive behaviours. Victims and survivors also learn skills of mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. However, eligibility for DBT groups often requires a diagnosis of Borderline Personality Disorder.

- **Eye Movement Desensitisation and Reprocessing**

  Eye Movement Desensitisation and Reprocessing (EMDR) helps victims and survivors of child sexual abuse to access and process the abuse by alleviating distress, restructuring negative beliefs and reducing physiological arousal. It includes aspects of exposure therapy and Cognitive Behavioural Therapy, and techniques such as rapid eye movements, hand taps and the use of alternating sounds. Victims and survivors specifically attend to abuse-related materials (for example by imagining an aspect of the abuse) in brief sequential doses while focusing on an external stimulus (such as engaging in repetitive, systematic lateral eye movements) at the same time. It is hypothesised that the process of attending to the abuse-related materials and the external stimulus interrupts the traumatic memory and associated negative emotions, and desensitises the victims and survivors to distressing aspects of the abuse. It is also hypothesised that this process mimics the Rapid Eye Movement (REM) sleep cycle and therefore facilitates subconscious re-processing of the abuse.

- **Mindfulness-Based Stress Reduction**

  Mindfulness-Based Stress Reduction (MBSR) teaches victims and survivors of child sexual abuse mindfulness skills; in other words, the skills to continually bring their attention to the present moment. These skills eventually lead to a shift in their perception in which they simply observe thoughts as arising events rather than become immersed in the valence and content of these thoughts. With increased ability to observe their thoughts non-judgementally, openly, curiously and receptively, victims

and survivors experience less psychological inflexibility, emotion dysregulation and rumination. Therefore, MBSR can serve as a form of exposure and work to alleviate the avoidant tendencies of victims and survivors because their relationship with negative thoughts is altered. By fostering a greater comfort level with thoughts previously avoided (and therefore being present to painful emotional experiences), mindfulness practice allows these thoughts to surface. This may reduce the frequency at which victims and survivors engage in efforts to escape or hide from abuse-related thoughts, feelings or memories, by attempting to suppressive intrusive thoughts, remove themselves from negatively evocative situations, engage in substance use, or engaging in emotional numbing. Mindfulness skills may also enhance the capacity of victims and survivors to be present in psychotherapy, and therefore facilitate therapeutic work.

- **Prolonged Exposure Therapy**

  There is evidence that Prolonged Exposure Therapy (PET) has positive benefits for victims and survivors of child sexual abuse, particularly because it targets their anxiety and phobic responses to the memories of the abuse. It specifically helps victims and survivors to develop or improve their abilities to control abuse-related thoughts and feelings by encouraging them to repeatedly confront abuse-related memories and situations that are usually avoided. PET aims to provide victims and survivors with information that is incongruent with their abuse-related cognitions, and to desensitise and habituate them to the abuse.

- **Psychodynamic Therapy**

  Psychodynamic therapy is based on the assumption that unconscious processes shape conscious thoughts and actions, and that negative thoughts and memories are intentionally excluded from conscious awareness. In particular, the therapist assesses the victim/survivor's strengths and weaknesses based, in part, on the nature and severity of the child sexual abuse, any sensitisation due to prior trauma, hereditary factors that impact the victim/survivor's defensive functioning, and the victim/survivor's developmental stage and their environment at the time of the abuse. The therapist then helps the victim/survivor to recover from the abuse by modelling a supportive relationship and helping them to develop insight into the abuse (by identifying the meaning of their symptoms, for example).

- **Supportive therapy**

  Supportive therapy refers to the use of a range of therapeutic techniques and focuses on the development of a supportive, emotionally-involved therapist-client relationship. It specifically empowers victims and survivors of child sexual abuse to guide the content of the therapy session and encourages the therapist to avoid providing direct advice.

- **Trauma-Focused Cognitive Behavioural Therapy**

  It is hypothesised abuse-specific CBT has positive benefits for victims and survivors of child sexual abuse.[i] This is because it is a trauma-informed and trauma-specific/focused treatment, and utilises well-established treatment strategies to address specific symptoms of child sexual abuse, such as post-traumatic distress, anxiety, avoidance and depression. It specifically helps victims and survivors of child sexual abuse to understand, challenge and change abuse-related thoughts, feelings and behaviours, such as understanding how inaccurate and dysfunctional thoughts about the sexual abuse can lead to psychological distress and behavioural dysfunction. Notably, anxiety and avoidance are typically addressed via gradual exposure and desensitisation to abuse-related memories, stress inoculation and relaxation training, and the interruption and replacement of distressing thoughts and feelings. Depressive symptoms are typically addressed via coping-skills training and cognitive restructuring.

  While there are a number of agencies and practitioners who provide treatments to victims and survivors of child sexual abuse, further work is required to detail the therapies, interventions and modalities utilised and accessibility.

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

The scientific literature has shown promising results on the use of DBT groups. The importance of Continuing Professional Development programs that focus on evidence based therapeutic interventions is essential to ensure up to date knowledge and skills among staff. There is current research on the use of sensory modulation protocol to decrease agitation which may have application in supporting victims and survivors of child sexual abuse.

It should be noted there are varying levels of evidence for therapeutic interventions. Those considered well validated have been shown to be effective by researchers other than just the developers of the approach, results are significantly better compared to control groups who don't receive the intervention, use assessment measures that are well researched and validated and still show positive benefits at later follow up. Interventions that are considered promising or emerging may have only been shown to be successful in a limited number of studies. The following practices are validated by research evidence:

- **Cognitive Processing Therapy**

  When compared with control groups, the literature indicates that Cognitive Processing Therapy (CPT) significantly reduced symptoms of dissociation and post-traumatic stress disorder in samples of child victims and survivors of sexual abuse. CPT also significantly reduced abuse-related cognitive distortions in samples of female adult victims and survivors of sexual abuse.

- **Dialectical Behavioural Therapy**

  The literature indicates that Dialectical Behavioural Therapy (DBT) significantly reduced symptoms of dissociation and post-traumatic stress disorder (PTSD).

- **Eye Movement Desensitisation and Reprocessing**

  The literature indicates that Eye Movement Desensitisation and Reprocessing (EMDR) therapy significantly reduced symptoms of post-traumatic stress disorder (PTSD) in samples of child victims and survivors of sexual abuse.

- **Mindfulness-Based Stress Reduction**

  The literature indicates that Mindfulness-Based Stress Reduction (MBSR) was viable in a sample of adult victims and survivors of child sexual abuse, and safe and favourably endorsed by them, according to the qualitative data collected and the high rate of participation. MBSR also significantly reduced symptoms of depression and post-traumatic stress disorder (PTSD) in this sample, with these improvements observed eight weeks after the treatment began and remaining significant for at least another 16 weeks (when the study concluded).

- **Trauma-Focused Cognitive Behavioural Therapy**

  When compared with non-directive play therapy or supportive therapy, the literature indicates the provision of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) to samples of child victims and survivors of sexual abuse significantly reduced sexually inappropriate behaviours, feelings of shame and mistrust, internalising and externalising behaviours (such as absconding), and symptoms of anxiety, depression and post-traumatic stress disorder (PTSD). TF-CBT also significantly improved social competence in these children. In fact, the provision of TF-CBT to samples of non-offending parents of child victims and survivors of sexual abuse (without the children engaging in treatments themselves) significantly reduced symptoms of depression in these children.

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 following activities and initiatives are occurring and may provide useful information about how to better support adult and child victims of child sexual abuse:

In a health service context for example:

- Central Adelaide Local Health Network (CALHN) is undertaking work around domestic violence, rape and sexual assault;
- sensory modulation protocol research is being undertaken in both CALHN and SALHN;
- care planning frameworks provide the scope to assess needs and identify any child safety issues;
- the development of tools to assist practitioners in assessing victims of domestic violence and abuse;
- personal safety care plans being trialled in intensive care units; and
- there is an allied health focus on psychosocial rehabilitation.

The treatment of victims and survivors of child sexual abuse is complex. Treatment plans need to be individualised on the basis of the victims and survivors' clinical presentation and the context in which treatment will proceed. The treatment is even more complex for victims and survivors who experience other difficulties that need to be addressed as well (such as attachment, learning or emotional difficulties). These clients may require a more comprehensive treatment plan to address their experiences of child sexual abuse, as well as the other difficulties. For example, some of these victims and survivors may benefit from short-term abuse-focused therapy in conjunction with long-term relationship-based therapies in order to help them cope with everyday life. Other victims and survivors may require extensive self-work before they are able to commence any significant abuse-focused treatment. In addition, the treatment of child sexual abuse can help to reduce the associated short-term and long-term consequences if the treatment is trauma-focused, structured and aimed at specific symptoms.

Due to the nature of child sexual abuse, it often results in complex developmental trauma. That is, rather than a single incident of trauma, which may result in readily recognised and diagnosed disorders such as Post-Traumatic Stress Disorder, child sexual abuse is often chronic, interpersonal and occurs during a time a child is developing their sense of self and trust in relationships. Therefore, it can have an impact in multiple domains of functioning including affective, somatic (e.g. chronic pain), behavioural (e.g. self-harm, substance use), cognitive (e.g. attention, dissociation), relational (e.g. loss of trust or victimising others) and self-attributions (e.g. shame, self-blame). There is no current mental health diagnosis that adequately reflects the impact of child sexual abuse. In South Australia, Child and Adolescent Health Services see children without a diagnosed disorder; the absence of a clear diagnosis can be a challenge in providing support to adult consumers. It has been proposed by a number of researchers that there should be a diagnostic label of **Developmental Trauma Disorder** (Ford, Grasso, Greene, Levine, Spinazzola, & van der Kolk, 2013) or **Disorders of Extreme Stress**.

Finally, research is now indicating that all therapy for complex trauma should have a **Phase Based Approach** (Cloitre et al, 2012; Kezelman & Stavropoulos, 2012). Initial interventions should always focus on establishing psychological **Safety and Stabilisation**. This includes the person no longer being at risk of abuse or assault, reducing exposure to traumatic situations and having a safe place to reside. The second phase should focus on building

Relationships, both with the therapist but also focussing on improving the client's supportive and family relationships. At this stage, the therapy can also focus on building **Emotional Regulation Skills**, such as mindfulness or distress tolerance and building interpersonal relational skills. Only after these stages have been completed should therapeutic work begin on **Integration and Processing** of trauma related content.

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Appendix 1

WCHN State-wide policy role in child abuse and interpersonal violence

The WCHN has carriage of SA Health's Child Protection Policy Program. The focus of this program is to meet current and future demands across SA Health concerning child protection through the development of policies, procedures, training, culture and materials to maintain the care, safety and protection of children and young people. The WCHN also has responsibility for SA Health's Women's Safety Strategy which aims to support the WCHN and SA Health to meet current and future service demands through the identification of strategic priorities, aligned to SA policy directions that progress a population approach to women's safety. This includes oversight of SA Health's compliance with the Family Safety Framework and management of SA Health's responsibilities to the MAPS.

These two strategic programs are working collaboratively with direct service delivery agencies such as Yarrow Place, CAMHS, CPS and MAPS to develop and/or improve SA Health's child protection, domestic and family violence and sexual assault policy and embed trauma informed practice across the WCHN and other Local Health Networks. Strategies which include the training of health staff and written policy will assist to ensure a broader cross section of health professionals within the WCHN (and into the future other public hospitals and health services) are functioning in a trauma-informed way.

Creating a health service environment which is safer for children, young people and adults may promote opportunity for patient disclosure of current or past trauma so that better health care, including appropriate referrals, notifications and service responses can be provided.

WCHN state-wide services

The WCHN provides a number of specialist state-wide services that have specific approaches to advocacy, support and care and treatment. Information about these services is given below.

The WCHN services listed below all provide individual and systems advocacy. The WCHN is committed to working collaboratively with other services and agencies as children and young people's lives intersect with other significant systems such as education and child protection services. As a health network, close collaboration with, youth justice, criminal justice, housing and the Department for Education and Child Development (which includes Families SA) (DECD), is critical to better health outcomes for everyone.

This year, WCHN has been co-ordinating an inter-agency collaboration on APY Lands to work with community to address problem sexualised behaviour. This has involved the development of a draft action plan in partnership with APY community leaders and members. The Plan identifies the underlying risk factors for child abuse, neglect and sexualised behaviour together with actions to address and accountabilities. The WCHN undertook the role of leading this initiative in the initial phase and it is now overseen by DECD.

Yarrow Place Rape and Sexual Assault Service

Yarrow Place Rape and Sexual Assault Service provides:

- A mobile, intensive therapeutic care program for young people under the guardianship of the Minister (GOM) who abscond from placement and are being or are at risk of being sexually exploited. This program is based on a program offered in Victoria called Take Two which is trauma informed with a sound understanding of the neurobiology of trauma, child and adolescent development and complex grief and loss. The program is for young people referred by Families SA who are aged between 12–18 years of age however, the program will provide support until the young person is 25 years of age. The model utilises a therapeutic care team approach and assertive engagement strategies. Currently some of the staff are trialling Arianne Struiks six step assessment model with plan for the remaining staff to be trained in this approach in 2016. Staff provide individual and systems advocacy as required.
- Medical and forensic services, telephone or face to face office based counselling services to people aged 16 years of age and older who have experienced sexual assault. Approximately 50% of clients have a history of child sexual abuse. Counsellors will provide therapeutic services for both issues. Support is not session limited.

Child Protection Services

The Child Protection Service (CPS) at WCHN serves northern metropolitan and country areas and the Flinders Medical Service which is a part of SALHN serves the southern metropolitan and country areas of South Australia provides:

- Forensic investigation, assessment and treatment services to children from birth to 18 years of age where there is a suspicion or confirmation of neglect or child abuse, including child sexual abuse.
- Key partners for referral are Families SA and South Australia Police (SAPOL).

Child and Adolescent Mental Health Services

The Child and Adolescent Mental Health Services (CAMHS) is a state-wide specialist service providing mental health services for people from birth to 15 years of age, and their families. CAMHS provides a range of services and programs for children and young people in acute, community and day program settings, which may include:

- community visits
- clinics
- counselling
- psychological therapy
- Staff training in child and adolescent mental health issues.

Within SA, acute mental health services for infants, children and young people are provided through:

2. Women's and Children's Hospital (Boylan Ward)
3. Paediatric consultation and liaison services through Women's and Children's Hospital and Southern Child and Adolescent Mental Health Services
4. Infant and Perinatal Mental Health Services at Helen Mayo House.

There are several specialist mental health services for children and young people which include:

- Adolescent Services, provided at the Enfield Campus, run day programs for young people aged 12 to 18 years who experience significant mental illness, and their families,
- The Behavioural Intervention Service is a state-wide, intensive, specialist service for young people aged 5 to 18 years who have mental health issues and persistent, pervasive and challenging behaviours
- Mary Street: Adolescent Sexual Abuse Prevention Program is a program for young people aged 12 to 18 years who have committed a sexual offence, have engaged in inappropriate or offensive sexual behaviour or have sexually harassed others
- CAMHS provides an in-reach mental health service to the Adelaide Youth Training Centre (AYTC), which is managed by the Department for Communities and Social Inclusion
- CAMHS has also conducted specialist treatment on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands as a result of the Mullighan Inquiry.

Youth Health Service

The youth health service, MY Health Service provides:

- Health services to very vulnerable young people aged between 12–25 years of age.
- Priority is given to young people under the GOM and those in the youth training centre (incarcerated youth).
- Referral to other services (such as CAMHS, Yarrow Place and Uniting Communities) to provide therapy regarding child sexual abuse trauma.

Women's Health Service

Women's Health Service (WHS) provides:

- Health services to vulnerable and disadvantaged women including Aboriginal, Torres Strait Islander women and women with challenging health or life issues.

- Women can access short to medium term counselling and case management for child sexual abuse.

[i] Saywitz, K. J., Mannarino, A. P., Berliner, L., & Cohen, J. A. (2000). Treatment for Sexually Abused Children and Adolescents. *American Psychologist, 55 (9),* 1040-1049.