MonashHealth

South Eastern CASA
Centre Against Sexual Assault & Family Violence

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

Topic A: Victim and survivor needs and unmet needs

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

Children and young people who are survivors of child sexual abuse need advocacy, support and therapeutic treatment services that are appropriate to their needs. For children in well-functioning families these needs are met by the family, who will refer them for counselling.

For children placed in out of home care, it is more difficult. It is particularly difficult for Aboriginal children and young people whose rate of placement is approximately 12 times the rate of placement for non-Aboriginal children (CCYP Annual Report 2014/2015 page 45). Residential units need to have a close relationship with their local CASA. This would provide therapeutic interventions for young residents, secondary consultations and training for staff.

There are also other groups of children for whom the provision of these services is difficult – children who have recently arrived in Australia and children with a disability.

There are a number of agencies, including most CASAs, who work with children who have been abused. In our experience it is essential to have an open model which allows the agency to provide a range of approaches. Practitioners need to have specialist expertise in working with children who have been sexually assaulted. In addition, they need time to engage with a child and win their trust. Agencies need to be able to do longer-term work with a child or young person rather than have a fixed session model.

There are 12 agencies, 9 of them CASAs, who work with children with sexually abusive behaviours (SABs) as well as the victims. These agencies are part of the peak body CEASE. SECASA's program is the AWARE program. It provides services for children and young people with problem sexual behaviour (PSB) and sexually abusive behaviours (SABs), from the age of 4 to 18 years, while providing support to their parents and carers.

Referrals to Sexually Abusive Treatment Services (SABTS) come from DHHS, police, parents/carers, health professionals, schools, government departments and statutory authorities and courts. There is considerable evidence that intervening early with children and young people exhibiting SAB can help to prevent ongoing and more serious sexual offences (Pratt, Miller & Boyd, 2010; Pratt, 2013; Pratt 2015; Rich, 2003, 2005) Programs provided to children and adolescents may result in changes that are difficult to replicate with adult sex offenders due to the entrenchment of their behaviours. Thus it is important that children and young people exhibiting PSB and SAB have access to timely and effective treatment programs.

It is important that practitioners who work with children have the opportunity to update their skills regularly. The sexual assault field in Victoria has a government funded workforce development program which is run for the CASA Forum through SECASA. This provides free of charge, 22 days of training a year for practitioners. The training includes both Essential Foundations workshops for those who are relatively new to the field and Advanced workshops for more experienced counsellor/advocates. The training for the first Semester of 2016 will focus on working with children.

In addition, there is funding from the Victorian government to provide training and peer mentoring for the Sexually Abusive Treatment Services (SABTS) field.

2. What do victims and survivors need but not receive?

- Responsive, timely targeted interventions
- Unlimited number of sessions
- Stable staff in Child Protection, CASAs and other agencies providing sexual assault services
- Flexible schooling models (children may not be able to attend school for a full day due to concentration issues, and there is a need for innovative education models that support a child's therapeutic needs as well as educational)
- An awareness of cultural factors for each child
- Provision of counselling by counsellors with an individual focus. Counsellors who lack experience and knowledge of sexual assault can inadvertently harm victim /survivors. A lack of knowledge of the impacts and nuances of sexual assault can lead to naive questions and or statements which can further harm victim. Such responses can send victim/ survivors into a spiral of self-blame and shame.
- Provision of care by qualified practitioners. Unqualified practitioners can lead to boundary violations and cause further harm to victims.
- A choice about where support is provided. For some victim survivors, provision of care by service providers in systems where abuse has occurred (i.e. religious institutions) can cause further harm. It is imperative that victims and survivors have a choice about where they seek support.
- Better matching of youth with residential and other placements, which is currently difficult due to systems stress and lack of placement options.

One of the current difficulties with young people in out-of-home care is that they have remained in their family of origin until they are emotionally damaged and find it hard to make attachments. This makes it difficult to place them, and for workers to engage with them, because these young people in many case do not trust adults. We need a better system of risk assessment of parents so that children are not subject to multiple placements in a short period of time. Whilst it is preferable that every child remains in their family of origin, some adults are not capable of parenting children. This does not mean that they should not see their children, but that they should not be the primary caregiver.

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?

- Items that help or facilitate:
  - The capacity to obtain timely appointments
  - The ability to return to a service whenever you need to
  - Stable staffing model for the residential care staff and therapeutic staff
  - Separate facilities for victims of child sexual abuse and young people with sexually abusive behaviours
  - Flexible schooling models
  - An integrated service system such as the existing sexual assault support network across Australian facilitating access to support services for victims and survivors, providing options to ensure their needs are met
  - In Victoria the CASA Forum provides a comprehensive state wide response for victims and survivors. The CASA Forum provides individual, child, adult, family and systemic

responses for victim survivors of sexual assault. Within this network practitioners play the dual role of counsellor and advocate. Counsellor advocates provide both therapeutic support and advocacy through the various systems within the victim/survivor's life and the broader sector. Education and training within the community is an integral component of the role of the counsellor advocate.

- Barriers – same as for question 2 above, in reverse.

One of the difficulties for children in long-term out-of-home care is that they do not have someone who knows them, who provides them with consistency and makes them feel special. In the Commission for Children and Young People Report "…as a good parent would…" a young woman said "I don't feel special to anyone."

Even if we provide good out-of-home-care and specialist treatment services, children and young people need someone for whom they are special. Someone who knows they hate striped socks, remembers their birthday or that they don't like spaghetti. Whilst these things seem minor, given the difficulties in the lives of some children and young people, they are the sort of things that good parents know. A young person needs a significant other in their life who they can talk to and celebrate or commiserate with. This is ethically and professionally a difficult role for therapeutic staff. It is also hard to provide, but worth the effort, as reported by a number of young people we have had contact with.

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?**

There appears to be an inconsistency in how agencies respond to the needs of secondary victims. This is often related to funding levels and general capacity. If there is a waiting list of several months you are unlikely and unable to broaden the category of people you see.

There needs to be:

- A mapping exercise and a research project into the effects for secondary victims of the sexual assault.
- An agreed definition of what constitutes a secondary victim.

Whilst providing support for secondary victims is an integral component of the work within the CASA Forum network, victims are given priority for appointments. Parents, siblings and partners can be actively involved in the counselling process either in relation to the victim/survivor or for specific support for the needs of the secondary victim.

Topic B: diverse victims and survivors

1. **What existing advocacy and support and/or therapeutic treatment services are available which 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?**

People with a disability, both physical and cognitive, experience difficulty in accessing advocacy and support services. Working with these clients takes more time and enhanced/different skills to treating other victims. Furthermore, additional resources are required to provide the external

supports that are often needed. Services need to be accessible to people with a physical disability, and sensitive to the needs of people with a cognitive impairment.

SECASA offers the Making Rights Reality (MRR) program which grew out of a pilot project with the Federation of Community Legal Services. This program supports people with cognitive impairment or communication difficulty to report sexual assault. It does this by acknowledging that this group of victim/survivors require a stable worker and more time. The workers at SECASA were trained by SCOPE and other agencies to use communication aids. Training has been provided for workers from other CASAs.

The purpose of the pilot project was to increase access to the criminal justice system, counselling and the Victims of Crime Assistance Tribunal by providing additional support, resources and advocacy to assist people with cognitive disabilities and complex communication needs. Over the course of the project 102 people with cognitive disabilities and/or complex communication needs accessed SECASA's service.

Elements of the project included: training staff to work with people with cognitive disability or complex communication needs; availability of brokerage funds to pay for attendant care, communication support or transport; provision of outreach counselling or legal appointments; advocacy in relation to the criminal justice system, particularly in relation to disability-related discrimination in this system (for more on this see VHREOC's 2014 *Beyond Doubt* report); training of counsellor/advocates by the Office of the Public Advocate as Independent Third Persons; development of easy read information about sexual assault; and collation of counselling resources.

The model has increased the number of referrals received by SECASA from people with a cognitive impairment. A SECASA project worker is dedicated to the program for a specified time each week in response to demand. She provides a central referral point for outside agencies and secondary consultation for workers. We recommend this model should be funded across all CASAs for people with a cognitive impairment and communication difficulty.

The pilot project was evaluated by Dr. Patsie Frawley from La Trobe University and the report can be found here: http://www.secasa.com.au/services/making-rights-reality-for-sexual-assault-victims-with-a-disability/.

Key recommendations from this report were that:

- The Making Rights Reality Program should continue at SECASA and Springvale Monash Legal Service (SMLS). (This recommendation has been implemented)

- SECASA and SMLS should continue to collect and report data about people with cognitive impairments and/or communication difficulties and other disabilities. (This recommendation is being implemented)

- Evaluative feedback be sought from MRR clients of SMLS and SECASA

- That the MRR program be rolled out across Victoria by the CASA Forum

- Further advocacy work should be undertaken with the disability service and disability advocacy sector to carry out the following (this recommendation is being implemented):
    - Promote MRR in the South Eastern Region

- Enhance access to sexual assault and associated legal services for victim/survivors of sexual assault who have disabilities as a program
- Promote the need for MRR services as a service and advocacy issue across Victoria

Given the high rates of sexual assault experienced by people with disabilities (for a summary see Murray, S. and Powell, A. (2008) Sexual assault and adults with a disability: Enabling recognition, disclosure and a just response, ACCSA), being able to access advocacy and counselling services is essential.

Because victim/survivors with disabilities can face many obstacles in navigating the criminal justice system, the importance of advocacy cannot be understated. It is also imperative that accommodations and adjustments are made to therapeutic approaches to ensure that people can speak to a counsellor if they wish. These may include practical changes (such as provision of outreach, or ensuring availability of accessible facilities) or adjustments made in the sessions, such as use of easy read materials, pictures, talking mats etc.

For all victim/survivors, the CASA model, whereby both therapeutic and advocacy needs are addressed by the same counsellor/advocate, enables victim/survivors to be provided with a holistic response whilst reducing the number of people needing to hear their story.

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?

See information given for question 1 above, plus:
It is important to make the physical surroundings within an agency welcoming for all groups of people, for example rainbow stickers. Autism/ASD/ADD populations may need timeout/time in rooms.

The intake form needs to have more options than 'male and female', to include gender diversity and it should not assume that everyone is in a heterosexual relationship. Literature needs to be provided in easy-to-read English; for example, SECASA has a set of Easy-to-Read Brochures about sexual assault.

SECASA has created posters using Indigenous artwork which provide a more welcoming and inclusive environment for Indigenous service users. Another move to create a more inclusive feel within a building is demonstrated by the welcome wall in the foyer at the Dandenong Multidisciplinary Centre (MDC).

As with the MRR program, similar programs should be implemented which meet the specific needs of victims and survivors from both CALD backgrounds and indigenous communities.

Sexual Assault services have trialled colocation with Indigenous community groups. Colocation has created increased access, along with making professional links to indigenous communities and providing accessible information which both acknowledges and respects indigenous culture.

Many CASAs have actively employed counsellor advocates from CALD backgrounds, which models acceptance and inclusion for victims and survivors. This practice needs to continue.

CASAs should consider colocation with CALD community support groups and making links with professionals in CALD communities. This will enhance access and support for victims and survivors in these communities as well as providing education for these communities.

3. What would better help victims and survivors in correctional institutions and upon release?
Victim survivors living in correctional institutions should be able to access similar services to those offered in the wider community. On release they should be able to access the general service system and this should be organised as part of the pre-release planning. There needs to be a discussion about the provision of services post-release to this group.

Whilst the Youth Justice Custodial Practice Manual outlines procedures in relation to young people, and *Mental health treatment, professional behaviour and boundaries* and *Contacting the Police* contain some material related sexual assault, a specific document is needed about how to deal with victim/survivors of sexual assault.

Joint planning should take place between corrections, child protection and counselling services to ensure continuity of services and assessment of placements prior to release. Greater collaboration is needed between corrections and the services that might work with a young person when they are released.

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 remove areas)?**
    - Lack of public transport
    - Travel time and distance
    - Geographical isolation
    - Lack of affordable housing including public housing
    - High indigenous populations
    - Increasing refugee communities within rural and regional areas
    - Lack of interpreting services
    - Local community relationships complicate the provision of services; for example if the offender is an 'upstanding community member' there will be a division in the community about what happened
    - Ethical issues in relation to privacy and confidentially when service providers reside in close proximity to victims and survivors.

2. **What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?**
    - Technology and access to technology for the delivery of counselling/advocacy services
    - Support financially to victim/survivors to access appropriate technology
    - Petrol vouchers/subsidised travel on V line and other transport networks
    - Witness evidence facilities within the Multidisciplinary Centres (MDCs)
    - Access to legal information/representation in relation to family court/children's court matters
    - Reliable internet services are less likely to be available in rural/remote areas
    - Improved access to legal information and legal representation in relation to family court and children's court matters

- Building capacity in smaller communities/partnerships with general agencies

Topic D: Service systems 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?**

It is important to acknowledge that the overwhelmingly majority of victims and survivors are women and children. It is imperative that this is acknowledged and that gendered language is used to describe victim survivors. Likewise perpetrators of sexual assault are mostly male 80% (*National statistics Crime and Safety Survey, Australian bureau of Statistics 2006*). The gender of perpetrators should also be acknowledged.

It is SECASA's experience that some clients dislike the labels victim or survivor. An alternative is people who have experienced sexual assault. However it is lengthier and, on occasions, creates a sentence that does not fit into a document.

2. **Given the range of services victims and survivors might need and use, in 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?**

The service delivery model used by CASAs is a 24 hour model. It provides crisis care, support and advocacy (telephone and face to face) and therapeutic counselling interventions. The actual intervention provided can vary and is tailored for particular groups such as children, young people, adults, parents, partners, Aboriginal people, CALD communities and those with disabilities. For example the Making Rights Reality program at SECASA.

The CASA model provides crisis care for victims up to 2 weeks following a sexual assault, and in some cases a physical assault. Crisis care involves a response within a very short period of time. There is collaboration between CASAs, the state-wide after-hours Sexual Assault Crisis Line (run by the Royal Women's Hospital), DHHS Child Protection teams, local Victoria Police Sexual Offences and Child Abuse Investigation Teams, hospital emergency departments and the Victorian Institute of Forensic Medicine. There are a range of protocols which apply to crisis care which include the Police Code of Practice for the Investigation of Sexual Assault. Each CASA has a quarterly police liaison meeting which fosters close relationships and deals with any issues that arise.

An integrated service system such as the existing sexual assault support network across Australia, facilitates assess to support services for victims and survivors and provides options to ensure their needs are met.

In Victoria the CASA Forum provides a comprehensive state wide response for victims and survivors. Through the CASAs, the CASA Forum provides individual, child, adult, family and systemic responses for victim survivors of sexual assault. Within this network practitioners play the dual role of counsellor and advocate. Counsellor advocates provide both therapeutic support and advocacy through the various systems within the victim/survivor's life, and in the broader sector.

There are protective concerns when children and young people are victims of sexual assault. It is essential that there is a close relationship between local CASAs and the Child Protection service. In Multidisciplinary Centres (MDCs), collaborative relationships between police, child protection and CASA are facilitated by the colocation of the 3 services and underpinned by training and regular governance meetings. It is recommended that MDCs be established in the regions that do not currently have them, to facilitate improved services for victim survivors. The Deakin University evaluation of the MDC pilot project found that victim survivors received a better service from the MDC model. A new evaluation is due to be completed in December 2015.

Barriers for victim/survivors within this network are lengthy waiting lists, which may leave victims and survivors waiting months for a service. Alternatively victim/survivors feel compelled to seek support from private practitioners whose fees can be overwhelming and who may not have the expertise and knowledge of sexual assault that is necessary to actively support a victim/survivor. Increased funding to meet the demands for counselling within the sexual assault network is imperative.

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?

In 2008 the CASA forum began the State-wide Sexual Assault Workforce Development project (SSAWD). SSAWD is a Victorian government funded program to improve the quality and consistency of responses to victim/survivors of sexual assault. The program aims to develop sexual assault workers' competence and confidence and improve service quality and consistency. SSAWD is developing and delivering training to new and existing sexual assault workers on a range of topics. In 2011 the project was awarded recurrent funding.

CASA Forum, and SECASA as the lead agency, work in partnership to implement, manage and monitor the SSAWD program. AIFS (Australian Institute of Family Studies - Sexual Violence Research) continues to assist the program by providing information on current research and developments across the field of sexual assault.

There are two major responsibilities of the Workforce Development Program.

- To provide a total of 22 days of workshops per annum.
- To distribute and maintain the Community Education Package

Copies of training calendars can be viewed on the CASA Forum website.
http://www.casa.org.au/professionals/workforce-development/

It is crucial that professionals providing support for victims and survivors have an understanding of and ongoing training in the following areas:

- An ability to respond to the immediate needs of victims
- A sound understanding of sexual assault and the impact on both children and adults

- A systemic understanding of the role of gender and power in the context of sexual assault
- A focus on victims' rights in the context of sexual assault
- Familiarity with legal statutes in relation to sexual assault.
- Familiarity with trauma informed models of care
- Familiarity with diverse groups.

The SSAWD program provides regular training which addresses all of the above mentioned areas.

It is critical that practitioners who provide advocacy support and therapeutic treatment are adequately trained, qualified and experienced. CASAs generally employ counsellor/advocates with social work and psychology degrees. CASAs also provide student placements, and promote best-practice approaches for working with people who have been sexually assaulted by providing training and secondary consultation within the community.

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?**

Since 1979 sexual assault services have been providing victim focused counselling and advocacy for victims and survivors of sexual assault. CASAs support women, children and men who are victims and survivors of sexual assault, as well as secondary victims. CASAs are committed to addressing inequalities which result in the perpetration of sexual assault and violence against women and children. Violence prevention programs and community education are an essential component of service delivery within the CASA network. These programs seek to inform community understandings of sexual violence, countering misconceptions with current data and facts about sexual assault.

Feminist principles and rights-based perspectives prioritise service users' rights to informed consent, information, confidentiality and respectful responses. Victims' rights and systemic components are mirrored in emerging trauma informed models. Sexual assault is a social issue that occurs because of power imbalances in the family and in the justice, political and economic systems. Elimination of sexual assault and its effects can be achieved through attitudinal, social and structural change (Northern CASA philosophy). The CASA Forum would argue that a gendered analysis is an essential component of any model of service provision for victims and survivors of sexual assault.

Feminist principles acknowledge that men and boys are also victims of sexual assault. Dynamics of power are present for men and boys who experience sexual assault. Boys and men are predominantly sexually assaulted by men who are bigger, stronger and/or in positions of power in relation to their victim. CASAs acknowledge that some women perpetrate sexual assault.

CASAs provide a safe place for victim survivors to talk about their feelings in their own way. A feminist framework is presented within counselling and group work programs across the CASA network, to acknowledge and re-frame some of the internalised misconceptions that victim survivors may carry as a result of sexual assault. CASA workers seek to empower each victim survivor

through recognition and articulation. Decisions made by victim survivors are validated, accepted and the counsellor advocate provides advocacy at every relevant point, within a strict code of confidentiality (see information about sexual assault on the CASA House website: http://www.casahouse.com.au/index.php?page_id=133

Judith Herman's seminal text '*Trauma and recovery' 1992* continues to this day to provide a comprehensive and flexible framework for therapeutic support of victim survivors of sexual assault. Her three phase model of recovery model:

- Establish safety
- Remembrance and mourning/processing trauma
- Reconnection with others.

This model has formed a foundational guide for the CASA Forum and melds with feminist structural models. Victim survivors may need considerable time to establish a sense of safety both personally and within the therapeutic relationship. The trauma literature continues to recognise core stages for treatment and recovery.

There are many emerging innovative practices for victim survivors. No one approach works for all victim survivors of sexual assault; it is important that counsellors working in this area are familiar with a range of modalities that can be individually adapted to each client. Below is a summary of several such practices:

Restorative Justice
SECASA and the Gatehouse Centre have provided Restorative Justice conferences for approximately 2 decades. The Centre Against Violence in Wangaratta will commence a Restorative Justice project in 2016. SECASA is due to commence a Restorative Justice pilot project that will be evaluated by Monash University, Michael Kirby Centre for Public Health and Human Rights. These conferences have anecdotally been successful.

Neurobiology and trauma
The field of neurobiology and trauma has greatly influenced direct service provision for victim survivors of sexual assault. There has been unprecedented growth in the field of neurobiology and trauma in the last decade. As Fisher (2003) states 'to actually desensitize or transform a traumatic memory, we need either to change the mind-body responses to that memory or to reinstate activity the frontal lobes to interpret the responses differently as sensation rather than threat'.

Somatic therapy
Integrating the body into therapy is essential in supporting victim survivors of sexual assault. In the mid 1990s SECASA began a dance therapy program which highlighted the link between the physical self and recovery. Around this time Van der Kolk wrote his article 'The body keeps a score' (1994). Somatic therapy has continued to expand since this time. Figural therapists in this area include Babette Rothschild, Pat Ogden and Janina Fisher. All of whom have been highly influential in the sexual assault sector. Workers in the Victorian sexual assault sector have been offered extensive training in somatic therapy.

Trauma informed yoga
Trauma Informed yoga is an emerging intervention with considerable practice based evidence. A number of Victorian sexual assault services have incorporated trauma informed yoga into service delivery including West CASA and SECASA.

Below are details of a recent journal article which reviewed the efficacy of trauma informed yoga:

B. van der Kolk; L. Stone; J Wes; A. Rhodes; D. Emerso; M. Suvak; J. Spinazzola. (2014) Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomized Controlled Trial, J Clinical Psychiatry 75:0, Month.

Acceptance and Commitment Therapy (ACT)

ACT combines cognitive behavioural therapy with behavioural psychology and mindfulness training. Recently counsellor advocates at Eastern CASA have created a group program using Trauma focused ACT (TACT). The TACT program is informed by ACT, but is guided by trauma theory and draws on attachment and systems theories, body-centred therapy and developmental neurobiological research. These approaches were integrated to create a comprehensive program that adequately addresses the complex needs of survivors of sexual assault trauma.

The TACT program also draws on ACT-based mindfulness, acceptance and values-based processes. Participants are also taught about the neurophysiology of trauma and the importance of titrating physiological arousal in trauma recovery (Bearup L. Burrows C. & Murray G.;2015) ('titrating' can be thought of as providing a reagent or control mechanism).

Relational Treatment of Complex Trauma

Fundamental attachment disruptions are at the core of complex trauma, and the treatment must match the problem. The development of a therapeutic relationship, one characterised by four essential elements: respect, information, connection, and hope (RICH), is a primary dimension of the relational approach. Ideally, treatment includes elements presented in the RICH model (Pearlman L. & Courtois C.2005)

The Structural Dissociation model

The structural Dissociation model is an emerging model which provides a unique perspective on the impact of complex trauma. It offers a lens which seeks to empower victims over intrusive and immobilising symptoms which arise following complex trauma.

Van Der Hart, Nijenhuis, & Solomon theorise that Structural Dissociation of the Personality (SDP) is where "the personality of traumatized individuals is unduly divided in two basic types of dissociative subsystems or parts. One type involves dissociative parts primarily mediated by daily life action systems or motivational systems. The other type involves dissociative parts, fixated in traumatic memories, primarily mediated by the defence action system. The more severe and chronic the traumatization, the more dissociative parts can be expected to exist." (Van Der Hart, Nijenhuis, & Solomon, 2010, p.76).

These two subsystems are called Emotional Parts and Apparently Normal Part/s as first described by Charles Samuel Myers. The Emotional Parts (EP) is believed to be created because it cannot be absorbed/processed by the human mind and body systems. So the EP, limbic right brain part of the self holds both the trauma memories and the survival responses separate from ordinary consciousness. The Apparently Normal Part (ANP) carries on with normal life with life and continues functioning as it used to until the EP is triggered.

Trauma Focused Cognitive Therapy

Trauma Focused Cognitive Therapy (TFCT) has been well researched and documented as the method of choice for survivors of trauma. Pioneers in the field of sexual assault such as Foe have

documented this approach widely. Many sexual assault workers incorporate elements of TFCT into their work.

Alternate Therapies
SECASA has run a number of groups for victim/survivors who require a different approach for a period of time to talk therapy. These groups have included reflexology, yoga, art, employment and body awareness.

Other:

- Animal assisted therapy
- Accelerated Trauma Recovery
- Mandala therapy

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

In Australia, the unrelenting need to deliver services has understandably taken priority over evaluation of sexual assault services. As noted earlier, the Making Rights Reality (MRR) project has been evaluated.

Restorative Justice practices generally have been extensively evaluated. Restorative Justice conferences with victims of sexual assault or family violence have not been evaluated. However, a pilot project is due to commence on 1.1.16 by SECASA with 50 victims who choose restorative justice as an option. The evaluation is being undertaken by Monash University, The Michael Kirby Centre for Public Health and Human Rights.

The body awareness and reflexology groups at SECASA have been evaluated by Professor Ruth Weber, Australian Catholic University.

Mindfulness meditation-based stress reduction (MBSR) is an intervention which has a considerable evidence base. In 2009 a pilot study of adult survivors of childhood sexual abuse who participated in an 8 week mindfulness meditation based stress reduction program was completed. 8 weeks into the program depressive symptoms had reduced by 65%, symptoms of avoidance and numbing were significantly reduced (Kimbrough, E.; Magyari, T.; Langenberg, P.; Chesney, M; & Berman, B., 2010)

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?

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