

RESPONSE TO ISSUES PAPER10: ADVOCACY AND SUPPORT AND THERAPEUTIC TREATMENT SERVICES

CANBERRA RAPE CRISIS CENTRE/SAMSSA

This paper is a response to the Royal Commission into Institutional Responses to Child Sexual Abuse's Consultation Paper Number 10: *Advocacy and Support and Therapeutic Treatment Services*.

This response is from the Canberra Rape Crisis Centre (CRCC) and its male survivor's service SAMSSA (Service Assisting Male Survivors of Sexual Assault). The CRCC provides counselling and support to women and children who have experienced recent or historical sexual assault and are living in the Canberra region, and their supporters. SAMSSA provides counselling and support to male survivors of sexual assault and their supporters. The CRCC has been in operation in the ACT since 1976 and is a provider of the Australian Government-funded Royal Commission Community-Based Support Services for the Canberra region. SAMSSA has been in operation since 1997.

Our comments are based on our clinical experience working with survivors of child sexual assault for close to forty years, and on recent research into trauma-informed care and treatment. Our experience is as front-line practitioners and clinicians, and this is the perspective from which we have prepared this response.

We find that the therapeutic and support needs of survivors of child abuse in institutions do not differ greatly from those of other survivors of child sexual abuse. Therefore we have written this paper from the perspective of working with all survivors of child sexual abuse, not just institutional abuse. Where survivors of child abuse in institutions have special needs we have pointed these out.

TOPIC A: VICTIM AND SURVIVOR NEEDS AND UNMET NEEDS

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

Child sexual assault is a significant issue in Australia (Fergus & Keel, 2005; Tarczon & Quadara, 2012). Within the CRCC, around 50% of our female clients, and 90% of our male clients, are adult survivors of child sexual abuse.

The impacts of child sexual abuse can be varied and complex, and run the range of adult psychopathology (Briere & Scott, 2013; Kezelman & Stavropoulos, 2012; Ross & Halpern, 2009). At CRCC and SAMSSA, adult survivors of child sexual abuse tend not to seek support directly in relation to their abuse, but rather in response to a crisis in the long-term strategy/ies they have adapted in relation to their abuse. Examples include addiction, dissociation, violence, dysfunctional relationship styles, and so on. Many adult survivors of child abuse have very chaotic lives and suffer from a range of social problems including poverty, homelessness, violence, difficulties in parenting, difficulties with relationships, and so on.

In working with survivors, we assume that the presenting 'pathology' is rational and originally adaptive. Many of the problems of adulthood stem from coping strategies that were originally protective attempts to deal with the trauma.

Survivors of complex trauma will often come to us with formal mental health diagnoses. These include schizophrenia or other psychotic disorders, bipolar disorders, depression, anxiety, addictive disorders or frank substance addiction, eating disorders, somatic disorders, dissociative experiences, sleeping disorders, sexual dysfunction, and personality disorders (particularly Borderline Personality Disorder). Survivors will often have been given more than one of these diagnoses in the past, depending on their circumstances and the part of the mental health system they dealt with. A usual 'cluster' of diagnoses for one of our clients is a psychotic disorder, at least one personality disorder, and depression and anxiety.

The fundamental aetiology of all these phenomena is usually the developmental damage caused by childhood trauma (Briere & Scott, 2013; Ross & Halpern, 2009). When the abuse occurs in critical periods of development, it can profoundly damage psychobiological, social and emotional development. The disorders and syndromes we see are, in actuality, often second-order effects.

From our point of view, what we usually see is a combination of all or most of the following: problems with attachment/relationships, phobic anxiety, inability to manage emotions, dissociative disorders, somatic dysregulation, and impaired self-concept.

Advocacy and support services

In terms of support services, victims and survivors potentially need to be linked to a range of services. The following list of service types are the primary services which are useful for survivors of child abuse, roughly listed in order of the level of demand, based on our experience.

- Domestic violence support/crisis accommodation (for women)
- Drug and alcohol addiction support
- Supported accommodation/public housing
- Financial assistance
- Crisis mental health services (emergency response or in-patient)
- Police, ambulance
- Other mental health services (other counselling, psychiatric etc.)
- Centrelink
- Relationship counselling/mediation
- Parenting training and/or support
- Legal advice/assistance with court matters
- Support within or leaving incarceration
- Job search/employment services
- Financial counselling/advice
- Domestic violence perpetrator programmes
- Sexual assault perpetrator programmes

In the ACT and surrounding areas of NSW, services like these and our own refer clients to one another via informal networks. With some organisations (such as the police and forensic health services) we have formal partnerships or MoUs, but the great majority of referrals are made informally. There are no services to support survivors of child abuse to find out about and access relevant support other than information on the internet or held by other services, usually in the form of brochures or service databases. As a result, most of our clients access services when they are

at a crisis point and some damage to their lives – such as the loss of relationships, loss of employment or accommodation, or criminal charges being laid – has already been sustained.

It is our experience that referrals between services often work better by not just providing information about services to survivors, but contacting the services on the survivors' behalf and sometimes accompanying survivors to intake into the new services – that is, a 'warm', rather than a 'cool', handover (Butler, McArthur, Thomson & Winkworth, 2012). This is because of the high levels of social anxiety, social isolation and mental health difficulties which are so often the legacy of child sexual abuse.

In terms of advocacy, what works for survivors is supporting them to access services. Most advocacy work in CRCC consists of petitioning other welfare or government services for support for survivors – most often financial or material support, placement in residential or other clinical/therapeutic services, practical support around transport, accommodation and home care, and helping survivors with local government and police. This can be particularly acute in a service like ours, where many of our clients have been found to be 'difficult' clients by other services as a result of their (trauma-influenced) behaviour. Not infrequently survivors are referred to us because no other service will continue to work with them.

There is also significant benefit for survivors and victims in advocacy to raise awareness and improve services/support for survivors. CRCC also does some systemic advocacy, usually as a part of established networks/fora or in partnership with other organisations, around changes to the law, policy, funding, or welfare service delivery.

Therapeutic treatment services

Effective therapeutic treatment can address underlying trauma-linked memories and their associated phobic responses and help survivors of child sexual abuse achieve emotional regulation and more secure attachment/relationship patterns (Briere & Scott, 2013; Herman, 1997; Ogden, Minton & Pain, 2006). Survivors benefit from therapeutic treatment delivered from a trauma-informed perspective (Kezelman & Stavropoulos, 2012), supported by a strong professional structure including a practitioner development framework based on current research, regular professional supervision, and access to support for vicarious trauma.

Victims of child abuse, particularly child sexual assault, generally experience more complex psychological damage and suffer from a wider range of effects than adult survivors of trauma. Complex trauma arising from child abuse usually requires significantly more sophisticated and intensive work than adult-onset PTSD (Kezelman & Stavropoulos, 2012). Standard PTSD treatment or conventional Cognitive Behaviour Therapy (CBT) is often insufficient as it does not address the learnt responses resulting from childhood trauma which are not amenable to conscious processes (Ogden, Minton & Pain, 2006; van der Kolk, 2003; van der Kolk, 2015). What is required is a combination of CBT, analytical approaches, mindfulness-based therapy, and somatic work (Courtois, 2004; Forbes, Creamer, Phelps, Bryant, McFarlane, Devilly & Newton, 2007; Kezelman & Stavropoulos, 2012). The precise modality utilised at any particular point will depend on the phase of treatment the survivor is in, as well as the survivor's individual circumstances. CRCC and SAMSSA endorse and work by the Adults Surviving Child Abuse (ASCA) Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery (Kezelman & Stavropoulos, 2012), and in accordance

with the National Standard for Services Against Sexual Violence developed by the National Association of Services Against Sexual Violence (NASASV, 2015).

We use as a framework the three-phase Trauma Model for working with survivors of trauma first developed by Herman (1997) and now widely accepted (Kezelman & Stavropoulos, 2012). The different phases of treatment and recovery involve different needs and different psychological tasks.

Phase One: Establishing safety (managing fear)

Phase One is focused on giving the survivor the tools to manage both external and internal (psychological) safety. The work involves helping the survivor manage his or her day-to-day levels of emotional arousal, usually experienced as fear or anger, which propel the survivor into the often maladaptive strategies he or she has been relying on to that point. These include drug and alcohol abuse, suicide and self-harm, isolation, violence, dissociation, compulsive behaviour and obsessive rumination.

There are three levels of establishing safety which need to be addressed in the following order:

1. *External safety*: working with the survivor to ensure she or he is physically safe and has stable enough living conditions to be able to do any effective psychological work. Common tasks include helping survivors escape family and domestic violence, locating accommodation, accessing medical treatment (including for mental health crises), obtaining financial support, and accessing drug/alcohol dependency treatment. This stage of treatment often involves a great deal of advocacy and other support.
2. *Relationship safety*: many survivors of child sexual abuse have experienced such trauma in their early relationships that it is not possible for them to form safe and satisfying attachments to others – what is often referred to as ‘attachment trauma’ or ‘developmental trauma’ (Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005; Shapiro & Levendosky, 1999; van der Kolk, 2005). Such individuals are not capable of working with therapists or support workers without experiencing a great deal of anxiety, which may generate inappropriate or counterproductive behaviours. This anxiety and distrust can be even worse for survivors of sexual abuse in an institutional context. Survivors of this sort often come to us with a long history of conflict with, or even being barred from, other support services. The work of this stage of treatment is simply to help the client build a level of trust in his or her ability to work safely with a therapist or support worker. It is our experience that it may take months of very regular, intensive work simply for the survivor to feel safe enough in the relationship with a therapist or support worker that further therapeutic work can begin.
3. *Psychological safety*: once the survivor is physically safe and stable, and has some level of trust in the therapist or support worker, work may begin on teaching the survivor basic skills for managing feelings of anxiety, fear, terror and panic as they arise in day-to-day situations. The work of this stage of treatment is to help survivors contain and reduce dangerous strategies (including self-harm and suicide), develop basic skills for managing intrusive memories, nightmares, panic attacks and dissociation, learn how to notice and manage affective triggers, develop tolerance of phobic responses to abuse memories and be able to accept the presence of strong feelings.

Phase One work is usually the most difficult and time-consuming phase of treatment, as it is the fear of the underlying memories and feelings about the abuse, rather than the memories and feelings

themselves, that keep the survivor 'stuck' in counterproductive strategies. Serious therapeutic work of subsequent Stages – processing strong feelings and learning new strategies for connecting with others – cannot be begun until the survivor has enough skills to manage the anxiety, often bordering on terror, that will inevitably be raised by that work.

Phase Two: Processing (accepting grief and mourning)

In Phase Two, the survivor accepts, experiences and expresses the feelings related to the abuse and makes new meaning from his/her experience (Briere & Scott, 2013; Herman, 1997). Tasks of this phase include supporting the survivor to experience and if necessary talk about the feelings created by the abuse, to define and understand them, and learn to accept them as they naturally occur. This stage of treatment often involves the survivor letting go of self-blame for the abuse, and the dissolution of feelings of shame. Phase Two tends to pass quickly, as once the survivor has given him- or herself permission to accept the strong feelings that are present, they are felt naturally and cease to be continually triggered. In this process the therapist often acts as a witness, on behalf of society, of the injustice of the abuse.

Phase Three: Integration (making new meaning and finding connection with others)

In Phase Three, the survivor develops skills for independent living, forms new relationships or re-connects with old ones, and begins to feel more securely attached to others (Herman, 1997). Tasks of this phase include supporting the client to come to a new understanding of the meaning of her or his life, identifying hopes and goals for the rest of his or her life, and developing skills in relating safely to others and managing the external world. This includes forming positive relationships and engaging with community, education and employment. This is the phase of treatment where classic CBT techniques of cognitive management and skills development are the most effective – prior to this point, anxiety and strong feelings tend to interfere with cognitive clarity.

The above is necessarily a simplistic description of what is often a very complex process. During any of the phases the survivor may be triggered by external events, parenting or family issues, significant anniversaries, health problems, or new trauma, and may find her- or himself either 'returning' to earlier psychological tasks or needing extra support for the work in the current phase. While the survivor would be expected to be in a much better place to manage the new difficulty in Phase Three as opposed to Phase One, some support may still be required in the later stages of counselling.

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?*

Non-trauma-informed practice

'Trauma-informed practice' is support or treatment which:

- recognises that trauma impacts a very wide range of functions and that many life skills may never have been learned (that is, it is not simply a matter of healing or 'restoring' function);
- is focused on helping the survivor manage emotion, particularly fear, and recognises that in the presence of fear cognitive skills may not be accessible;

- assumes 'problem' behaviours were originally adaptive and operates from a respectful, strengths-based framework; and
- recognises and respects the context of the trauma and the survivor's experience (Kezelman & Stavropoulos, 2012).

Survivors are sometimes not best served by the medical and mental health systems. For instance, traditional medication-based psychiatric care or standard CBT will be ineffective unless the survivor has established a degree of internal psychological safety and skills in managing fear, the work of Phase One of the Trauma Model as discussed above (Courtois, 2004; Forbes et al., 2007; Herman, 1997). In addition, while child sexual abuse very often leads to diagnosable mental health conditions, to focus on the diagnosed condition and away from the traumatic experience can, in our experience, lead to an overemphasis on symptom reduction and retard the survivor's recovery and growth (Herman, 1997; van der Kolk, 2001).

In one recent example, a long-term client of our service, having recently experienced a loss of a loved one, fell back on old anxiety-management strategies, which in his case took the form of talking about his unusual spiritual beliefs. He was referred by the authorities to the mental health system which, because his beliefs do not fit into a traditional religious framework, assumed he was suffering from psychosis and forced him to enter residential mental health care and take anti-psychotic medication, which led to some severe physical side-effects. The survivor told the treating psychiatrist that he had experienced abuse as a child but because some of his memories of the abuse are unclear (a not unusual situation – see for example Ross & Halpern, 2009), he was told that his story was untrue and further evidence of his psychotic illness. During the many months the client worked with this service he displayed no delusions, hallucinations, disorganised speech or behaviour, or other negative symptoms. His spiritual beliefs contain no more belief in supernatural events than most traditional religions (and in fact considerably less than most). The survivor described later that the hardest part of his experience was having his abuse history disbelieved and dismissed by the treating psychiatrist. Needless to say this period of incarceration has considerably increased his distress and exacerbated his symptoms.

In a similar way, support services which work with many survivors of child sexual abuse, such as the types of services listed under Question 1 above, may have difficulty working with survivors when they are not attuned to trauma-informed principles of service. Many survivors of child sexual abuse are 'difficult clients' and have a tempestuous history of working with support services. Our experience is that some survivors of childhood abuse, particularly abuse suffered in institutional contexts, can be 'service testers' – that is, people whose anxiety about engaging with any sort of organisation is so great that they will sometimes allow or even create conflicts with the service/s they are seeking support from. This behaviour may not be understood or under the conscious control of the survivor (Ogden, Minton & Pain, 2006; van der Kolk, 2015). Even where it is under the survivor's conscious control, it may be too hard for the survivor to avoid in situations of stress. Such survivors require tireless, long-term advocacy at great cost in time and energy to the supporting organisation/s.

This is not to say that survivors of child sexual abuse are not answerable for their behaviour. But it does mean that it is unrealistic to expect some survivors to be able to operate within the confines of institutional expectations *without appropriate therapeutic support*. The answer is a collaborative approach between welfare organisations and specialist therapeutic services.

Lack of residential treatment

A further noticeable gap in the current system is the lack of any affordable inpatient services for people in the acute stages of post-traumatic syndrome, other than public mental health services, which in our experience have a variable response to post-traumatic symptoms and dissociative symptoms in particular. Limited-stay inpatient facilities, along the lines of the Trauma & Dissociation Unit at Belmont Private Hospital in Queensland, could achieve a great deal with acute-stage survivors with very complex Phase One needs, which simply cannot be provided by office-based counselling services.

Time-limited treatment

Effective trauma therapy will often be long-term and intermittent. While all sexual assault has the potential to create significant post-traumatic responses, in our experience there is a significant difference in the level of expertise and time required to work with a survivor of child abuse (Courtois, 2004; Fergus & Keel, 2005; van der Kolk, 2005). In the CRCC's experience there can be no fixed limits on the number of counselling sessions a survivor might access if treatment is to be effective. Complex trauma can take many months to be effectively managed, depending on the severity of the abuse and the complexity of post-traumatic strategies adopted by the survivor. Having a cap on the amount of counselling available can make it impossible to address some of the more complex impacts of trauma, which in turn places strains on other services such as the mental health system, drug and alcohol treatment services, family relationship services and so on.

Having said this, counselling needs planning, a focus on measurable outcomes, and regular review as part of best practice (Briere & Scott, 2013; Kezelman & Stavropoulos, 2012). Wandering, unfocused counselling is of limited benefit to survivors and can entrench them in their 'trauma narratives' (O'Leary, 1999).

Cost of treatment

One key factor which limits survivors' access to therapeutic treatment in particular, is cost. A substantial proportion of survivors of child sexual abuse live in poverty, either because they are unable to work or keep a job, or have not been able to break free from poverty-level employment, due to mental health disability or behavioural difficulties. Many others are able to work but due to other trauma-influenced behavioural problems, such as substance abuse, domestic violence or relationship difficulties, are not able to improve their living conditions as well as less traumatised people.

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 these barriers be addressed?*

Effective cross-referral and networks

There is often some difficulty in establishing effective referral networks between specialist sexual assault services and other services which may, possibly unbeknownst to them, be working with adult survivors of child abuse.

Referral networks are important because, in our experience, adult survivors will often encounter other crisis or welfare services as a result of difficulties caused by their coping strategies.

Services/organisations providing addiction services, mental health services, domestic violence services, the criminal justice system and other welfare support agencies often encounter these survivors. Unless the underlying trauma-linked processes are addressed, it is likely that survivors will continue to cycle through and tie up the resources of these services as they fall back on old ways of dealing with their pain in the absence of a viable alternative. Such 'relapses' are almost inevitable in the absence of intensive Phase One work (see Topic A, Question 1 above). What is often required is on-referral to a therapeutic service which sometimes will work alongside, and sometimes take over from, the original crisis/welfare service.

From our experience, there are two issues with referrals into specialist sexual assault services such as our own. The lesser problem is that some services are not aware of the existence or the contact details of specialist services. The 'silo-ing' of welfare support services is a phenomenon which has been noted many times in the literature (Butler, McArthur, Thomson & Winkworth, 2012) and is, of course, a broader issue than just in the sexual assault service sector. However, this is becoming less of a problem due to the Internet and national databases held by such services as 1800-RESPECT and the Royal Commission.

The greater challenge is the reluctance of many services to raise the question of sexual assault, or childhood trauma generally, with their clients. Not asking the question means not knowing that a referral to a specialist service might be helpful.

We attempt to deal with this issue via regular networking and offering training in responding to disclosures of sexual assault, but our resources to do so are limited. Effective networking and encouraging cross-referral is not a difficult or mysterious process. We already know how to do it effectively. The main issue is having the resources and time to give establishing service networks the attention it deserves.

Service brokerage

One approach which in our experience has had some success is that of service brokerage; where one service or individual in the community is an expert on what services exist in the local area and can broker survivors' access to all the services they need. Some government organisations, such as Centrelink and, in Canberra, Housing and Community Services ACT, employ professionals whose role it is to provide this service and some level of support to survivors while they are trying to locate help.

The creation of a network of brokerage/support specialists, linked to key organisations (such as government bodies, health services or peer support organisations) would potentially be of great value to survivors. We would recommend the creation of a trial or pilot to properly test the effectiveness of this approach.

Case management mentoring

As discussed elsewhere in this paper, survivors of child sexual abuse often struggle when dealing with support services, and can be very difficult for services to work with. Some of these survivors can significantly tax the time and interpersonal resources of case workers and case managers, and as a result some are asked to leave the service before their needs are met.

One idea being trialled at CRCC is the provision of debriefing and clinical supervision for case workers in support services, where the case worker is working with a 'difficult' survivor who is also a client of the CRCC. This takes the form of regular, one-on-one conversations with the case worker around the best ways to relate to the survivor, and also to ensure the case worker does not 'burn out.' The purpose of the initiative in the immediate term is to keep the survivor linked to support services, and in the longer term to build skills and resilience in the welfare sector for working with survivors of this sort. Effectively, the organisation working with the client is offered support and professional development to do so. The supervision is provided by senior therapists from CRCC with experience in clinical supervision.

This model is being developed informally in only a couple of cases at present but seems to have promise. It might benefit from a more formal pilot or trial.

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?

CRCC defines 'secondary victims' as partners, family members and supporters of survivors who are affected by the survivor's response to her/his abuse. We work regularly with secondary victims and have found that this is often of great benefit to both the secondary victim and the survivor.

However we have also found that because of the impact of the abuse on the behaviour of survivors, their family/supporters often require support in their own right. These issues can be more acute for female partners/supporters of male survivors, as male survivors often have difficulties with relationships and/or use aggressive behaviour or violence within relationships. In addition, many women have their own experience of sexual assault or abuse which can be triggered by a partner's behaviour or story.

Secondary victims have two needs: information/psychoeducation about the impacts and effects of child sexual assault, and support with the impact the survivor's way of coping with the assault has had on the relationship. The first need is always present and the second is usually present.

In our experience, apart from specialised sexual assault services like our own, there are few information services available for secondary victims. Because of the specialised nature of the information the secondary victim needs, it should ideally be provided by a specialist in sexual assault and trauma-informed practice.

Most sexual assault services will also provide support to secondary victims. In addition, we know of at least two services, Living Well in Queensland, and the Survivors and Mates Support Network (SAMSN) in New South Wales, which have run group information programmes for secondary victims and we endorse that model.

In terms of the needs of secondary victims arising from the behaviour of the survivor, there are a range of services which a secondary victim might access. The most usual in our experience would be relationship counselling, mediation, and domestic violence and crisis accommodation services. While SAMSSA provides therapeutic support to partners of male survivors when required, this can sometimes be constrained by resources. On the other hand, there is no formal mechanism in the women's service of CRCC for providing therapeutic support for male partners of female survivors (where possible these are also picked up by SAMSSA). As far as we are aware this is the case with other sexual assault services working with women in Australia. So, male partners/supporters of female survivors may be a somewhat 'hidden' group of secondary victims

Children of survivors can also be a significant group of secondary victims, where the impact of a parent's child sexual abuse makes it hard or impossible for the survivor to provide appropriate parenting or safety. Such children are not usually picked up by welfare services until their distress becomes so evident they come under the eye of the broader child protection system. Services like ours, working with the parent, look out for risks to the child but this is a very fallible system, dependent on the disclosure of the parent.

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 victims and survivor groups? What types of models and approaches are used to address the particular needs of these populations?

The CRCC strives to make its services accessible by all diverse survivor groups via culturally sensitive practice, training for staff, use of translation services, and networking and formal partnerships with services, peak bodies etc.

For Aboriginal and Torres Strait Islander survivors we provide a separate service, Nguru, which provides advocacy and support for Indigenous survivors provided by Indigenous workers. Survivors have the choice of accessing Nguru services, broader CRCC services, or both. This choice is important as while many Aboriginal and Torres Strait Islander survivors prefer to work with an Aboriginal worker, many do not, and wish to work with someone outside their community due to stigma associated with sexual abuse.

A challenge in working with culturally diverse groups is that in some culturally based services, there is a reluctance to talk with their clients about sexual assault. Not asking the question means not knowing that a referral to a specialist service might be helpful. We attempt to deal with this issue via regular networking and offering training in responding to disclosures of sexual assault, but our resources to do so are limited. Probably linked to this, it is our experience, at least in the ACT, that some groups of survivors seem to prefer to stay within their own communities to seek support. This is particularly true of some CALD groups.

Similarly, while our facilities are reasonably accessible, we attract fewer survivors with physical disabilities than research into the prevalence of sexual abuse among people with disabilities (particularly in institutions) would lead us to expect. We do of course see a very high proportion of survivors with mental health disabilities.

CRCC sees a high proportion of LGBTIQ people and has a clear commitment to inclusive, LGBTIQ-friendly service which is clearly articulated in corporate policies and reflected in training and organisational culture.

Particular issues for male survivors

This section of the paper is written from the perspective of SAMSSA, the CRCC's specialised service for male survivors.

Research (Crome, 2006; Ogloff, Cutajar, Mann & Mullen, 2012) and the experience of the Royal Commission indicate that more boys than girls experienced child sexual abuse in institutions. However there are currently few services in Australia specialising in the provision of service to male survivors of sexual assault, with varying accessibility across the states. There is also a great diversity of service structures such as voluntary services, government-funded bodies and NGOs which greatly vary in service delivery. There are only two dedicated counselling services for male survivors in Australia, SAMSSA and Living Well in Queensland.

Male-specific services are often run from the same organisations as women's and children's services, which can be challenging to manage. Historically, sexual assault support services in Australia were established in response to the reality that sexual violence is a gendered crime, with the majority of victims being female and perpetrators male (Foster, Boyd & O'Leary, 2012). Many existing organisations are based upon feminist models, some excluding men from the organisation completely either as staff or clients, and some experiencing internal and external tensions and concerns when implementing male client services. An existing service recognized for its historical and current expertise in successfully engaging both male and female clients is the South Eastern Centre against Sexual Assault (SECASA) in Victoria.

Common recruitment standards in sexual assault services often preference female staff, with some exclusively employing women. This, along with other pressures linked to the gendered nature of welfare sector employment generally, has led to a lack of male workers in sexual assault services. While it is our experience that many men prefer or are happy to work with female workers, some male survivors will only consider working with male counsellors. There are also difficult security issues in men working with female workers when the man is using or has used violence against women.

We would also argue that while the essential biological processes of trauma are the same for both genders, working with men requires a somewhat different psychological, or perhaps a different cultural, approach. Because of the operation of cultural models of masculinity (Connell, 2005), men face different barriers to disclosure and discussion of their abuse, deal with a different type of shame and identity disturbance, and process traumatic emotions somewhat differently to women. For instance, men struggle with social shame around definitions of self-reliant masculinity, homophobia, and expectations that male abuse victims will become abusers, are more likely to manage their pain via substance use or violent behaviour, including suicide, and have fewer

resources for understanding and processing strong emotions (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; O’Leary, 2001; O’Leary & Barber, 2008; O’Leary & Gould, 2009; Olgoff et al., 2012;). In our experience the skills and expertise required to work successfully with male survivors of child abuse are different in important ways to those required to work with women, and require somewhat different training, support and organisational structure (i.e. the consideration of a separate or specialised service for male survivors).

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?*

Beyond the usual issues of facilitating survivors’ access to services, the specific challenge with survivors from diverse backgrounds is ‘breaking into’ the survivors’ communities to get information to them. Where survivors have a strong preference to seek support within their own communities and their own communities’ services and organisations, it may make more sense to make sexual assault support services available to them where they are.

There are two ways this could be done: providing training and resources for diverse-community-based services to employ in-house trauma workers, or establishing a framework and partnerships which would allow existing trauma workers, perhaps from local sexual assault support services, to work with clients of the diverse-community-service on its premises. The second option would probably be more effective, as it would involve less training, fewer hires, and run less risk of the trauma workers being unable to access peer support from other workers in sexual trauma. It would however require significant negotiation with community-based services, which might be most effectively driven at the state government level. Again, such an initiative may be worth trialling as a limited pilot.

If services wished to provide support in-house, training and short- to medium-term mentoring and clinical supervision could be provided by specialist sexual assault services along the lines of the model suggested in Question 3, Topic A above.

Another valuable initiative may be to provide resources to trauma education services (such as ASCA, ECAV etc.) to produce resources and provide targeted training for services working with survivors from diverse backgrounds.

3. *What would better help victims and survivors in correctional institutions and upon release?*

Survivors in detention or gaol benefit from time spent with them, but this is very much limited by resources (and made worse by the administrative difficulties in dealing with prisons). This problem is more severe where gaols and detention facilities are in remote locations.

Services and networks exist to help people leaving detention. In the ACT, for example, there is a coalition of services which provide support on a number of levels to people leaving detention: accommodation, drug and alcohol support, practical/welfare support, and social support. These service networks often overcome the usual problems of service identification and referral, because the range of problems are well understood and service delivery is already coordinated before the survivor re-enters the community. These services are only limited by their resources, and of course

in remote areas, this is exacerbated. This is a situation where we know what works, we just aren't able to do as much of it as we would like.

TOPIC C: GEOGRAPHIC CONSIDERATIONS

1. *What challenges to 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 availability of services for people living in regional and remote areas is a key service gap. Like many organisations, we do not have the resources or time to travel long distances to see survivors. We do have some clients who travel significant distances to see us, but this is a substantial impost on their time.

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

Rather than hoping for funding to establish services in more rural and remote centres, it may be more practical to build on services in regional hubs to give them the capacity to have outreach staff who can travel, either regularly or on an as-needs basis, to meet with remote survivors. Such staff would need both therapeutic and more general case management skills, as the survivor's locale may lack both therapeutic and also other support services. Ideally, arrangements could be made with government services, such as Centrelink or local councils, to provide occasional counselling rooms and some administrative support.

Another arguably less effective but more cost effective option would be for a centralised sexual assault service or expert body (such as ASCA) to provide training and individual clinical supervision/debriefing for staff of local services in the remote area who are working with the survivor.

In addition, on-line options for therapeutic support apparently show some promise, but we have no experience in this area on which to base any comment. We would warn against relying on on-line options at the cost of face-to-face service delivery. At least for the work of Phase One of the trauma counselling process (see Question 1, Topic A above) there is no effective substitute for warm, empathic face-to-face contact.

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?*

The CRCC is comfortable with the definitions of advocacy and support and therapeutic treatment in this Issues Paper.

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?*

Please refer to the suggestions for service improvement made throughout this paper. In essence all our suggestions come down to two issues: how to more effectively network and cross-refer between different support services, and how to use the expertise of specialist trauma therapy services to support not only clients but other service providers working with survivors.

One area we have not discussed much is online support. This is because we do not currently have the staff and resources to develop these types of support options. However, we will offer a general comment.

From the point of view of smaller services like ours, resource limitations make it difficult to provide online information and support to survivors, supporters and anyone else who might benefit from further information about institutional child sexual abuse. Rather than each organisation having its own collection of information, a more rational model might be a national website, perhaps run by a central organisation such as the National Association of Services Against Sexual Violence or ASCA, with a comprehensive collection of information, recent research and links to all relevant services, including links to services who offer online support via messenger services or videolinks.

3. *How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment services for adult and child victims and survivors, including those from diverse backgrounds?*

Accreditation and quality assurance

The cost of appropriate training and professional development in relation to sexual trauma is significant. Specialist sexual assault services, including the CRCC, are largely funded by State and Territory governments as part of the community/not-for-profit sector. As a result, it is difficult for us to attract more highly qualified mental health professionals. At the same time, existing undergraduate degrees rarely include a strong focus on trauma. Consequently sexual assault services need to provide much of the professional development workers need to remain up-to-date with complex trauma in-house, and from a limited budget.

As a result, while there would be value in some form of accreditation system for organisations working with survivors to ensure a basic standard of care, resource constraints may put achieving standard tertiary accreditation out of the financial reach of many existing services.

One solution may be a form of accreditation recognised by funding bodies and designed by experts in the field, but available via training from an expert body such as ASCA rather than through education institutions. The accreditation would only be available for employees of services working with survivors of sexual assault and be administered by an organisation, such as ASCA, funded specifically for the purpose.

A key component of such a scheme would be the need for service organisations to continually review and improve their services. At present most government-funded community sector services are required to evaluate their service annually as part of their reporting process to their funding

bodies, but this is focused largely on administrative and procedural processes, and any audit or quality assurance check is carried out by bureaucrats. Some form of regular quality assurance audit and oversight by an individual or organisation with therapeutic expertise, perhaps tied in with the regular reporting and funding cycle, would ensure the quality of service delivery for survivors.

Network

Working with survivors of child trauma, particularly providing therapeutic support, is a specialised field without a great many practitioners, many of whom operate in isolation from other services. In order to encourage the spread of expertise and mutual support it may be worth creating a national network of services working with survivors of child sexual abuse. This could be something along the lines of the Mental Health Practitioner's Network (MHPN). It could operate as a separate entity, or it could be an arm of an existing network such as MHPN. With such a network in place it might be possible for member services to jointly fund or develop training, seminars and other opportunities for the sharing of knowledge, particularly on-line.

TOPIC E: EVIDENCE AND PROMISING PRACTICES

Due to resource constraints the CRCC is not in a position to research or formally trial new initiatives, other than those described above.

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Canberra Rape Crisis Centre Management Group
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