30 November 2015
CCYPD/15/852

Advocacy and Support Officer
Royal Commission into
Institutional Responses to Child Sexual Abuse
advocacyandsupport@childabuseroyalcommission.gov.au

Dear Advocacy and Support Officer

Re: Advocacy and Support and Therapeutic Treatment Services

The Commission for Children and Young People (CCYP) would especially like to thank the Royal Commission for this timely opportunity to comment upon the advocacy for child sexual abuse victims, survivors and their families and the challenges they experience when seeking support and therapeutic services.

On 19 August 2015, the Commission released the report, "...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care (the Report), and a selection of the recommendations contained in this report are quite pertinent to this consultation. In broad terms, the Commission is concerned that there is a lack of formal advocacy consistent with a duty of care, for the needs of the cohort of current child sexual abuse victims living in residential care. Furthermore, it appears support and therapeutic treatment services are generally not child specific, or part of a differentiated response for children who reside in the care of the state. This is especially the case for Aboriginal and Torres Strait Islander children given the lack of services with capacity for culturally appropriate therapeutic and healing programs.

Similar issues arise in relation to the specific needs of survivors of child sexual abuse who have a disability, are from culturally and linguistically diverse backgrounds, especially those who are recently arrived or have had refugee and asylum seeker experiences, those from LGBTI (Lesbian Gay Bisexual Transgender Intersex) communities, or have been in custodial setting. The challenges are compounded when professionals with sufficient expertise capable of providing an appropriate service for clients who have complex needs due to dual or more diagnoses and/or who may fall within more than one of the diverse groupings are limited or unavailable.

**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 recent survivors of child sexual abuse need advocacy, support and therapeutic treatment services that are appropriate to their needs and culture. Those children who have family members that can advocate on their behalf for access to support and services may not be as reliant on the efforts of the professionals in their lives. However, children placed in out-of-home care are likely to have experienced abuse and neglect from which their family members were unable to effectively protect them. So when the child is abused whilst in care and the care service does not advocate strongly in their best interests, their family members are consequently unlikely to be in a position to undertake such advocacy and hold the care service accountable, leaving this group of children doubly vulnerable. This is especially salient for Aboriginal children and young people whose rate of placement in out-of-home care in Victoria is 62.7 per 1,000 compared to 5.1 per 1000 for non-Aboriginal children (CCYP Annual Report 2014-2015, p.45). Vulnerable children need a very proactive and effective response that promotes healing and resilience, coping and education strategies.
If a child's home environment has been one where violent and abusive behaviour was the norm, accompanied by associated social isolation, which is the lived experience of many children in out-of-home care, they would lack a frame of reference for being able to fully discern how inappropriate the behaviour is that they were subjected to and what could be done about it. This would increase the likelihood that the child did not have the opportunity to build strong social connections with other families and observe what behaviour happens when relationships are functioning well. Therefore when abusive behaviour occurs in the context of a residential care unit, the child may have added difficulty in being able to articulate the inappropriate nature of it and feel unable to trust anyone to tell them about it. There is also an inherent conflict of interest when the alleged abuser is a staff member, and it is only a little less complex when the alleged abuser is another child client or an external party given this raises issues in relation to how the unit is being governed and supervision and safety of clients.

The "...as a good parent would..." Report suggests in Recommendation Three, which refers to Listen to the voice of the child, that independent oversight and consistent responses to children in residential care is needed. It reaffirms the findings of this Royal Commission which have highlighted the importance of ensuring that children who disclose sexual abuse are believed and validated. When a sexual abuse allegation is made, it is essential that a rigorous and thorough investigation, which does not predetermine the validity of the allegation, is undertaken (p.21).

It is further recommended in the Report that a complaints body, which is independent of the Department of Health and Human Services (funder) and the Community Service Organisations (service providers), must be established to hear directly from children.

The Commission believes that the current Quality of Care (QoC) investigations should be delegated to such a body and the scope of such investigations expanded to include allegations of child-to-child abuse in residential care. The Report also recommends the development of revised and simplified guidelines to ensure a consistent response is provided to children who make a QoC allegation. The current response lacks a uniform child-centred focus and the child is not informed about how the process will occur and the outcome. It does not incorporate a feedback loop for children and when allegations are substantiated the child is not given access to a lawyer. It is proposed the response should include counselling, information about the process of investigation and its outcomes, and the child's legal right to access compensation and redress for substantiated cases. It is also proposed that improvement in the response to children who experience sexual abuse in residential care could be achieved by having a senior child protection practitioner (such as a Principal Practitioner) and the Community Service Organization's (CSO's) expert practitioner coordinating the investigation. There is also a need for timely completion of Critical Incident Reports (CIRs), referral to the complaints body for QoC matters, and provision of immediate support and counselling for the child, and where appropriate, their family members (p.21).

The Report also recommends that the current Independent Visitor Program (IVP) pilot should be established in all Victorian residential care units. The role of the independent visitor is to visit children and young people living in residential care, in order to learn about their experiences, promote child-safe practices and encourage cultural and community connections. It is noted that similar programs are in operation in other states of Australia and around the world (p.116).

At the current time, if a child in care makes an allegation of sexual abuse, generally a referral by a case manager would be made for this child to attend the local sexual assault service which is generally a Centre Against Sexual Assault (CASA). CASA's clientele were traditionally adult women who had experienced sexual assault or were survivors of historical child sexual abuse, but have more recently developed expertise in working with child survivors. The exceptions to this historical service model were the Gatehouse Centre at the Royal Children's Hospital, the Children's Protection Society and the Australian Childhood Foundation, which solely provided services specifically designed to respond to the needs of children. In more recent years, the Statewide Sexual Assault Workforce Development program has sought to provide practitioners with improved knowledge and skill development through both Essential Foundations workshops for those who are relatively new to the sexual assault sector and Advanced Workshops for those who are more experienced counsellor/advocates and sexual assault support workers. The training focus for the first semester of 2016 has a focus on working with children such as Trauma Focused Therapy working with children and Applying solution focussed narrative therapy when working with children.
In all of these services, practitioners may have specialist expertise in working with children in relation to the issue of sexual assault, but part of the counselling process will require rapport building to facilitate engagement, as the child will not be familiar with the counsellor until a referral is made post disclosure. Better outcomes are likely if the residential care unit develops a close relationship with the local sexual assault service that would facilitate secondary consultation and earlier intervention by professionals who had a good working relationship with residential care staff and ideally some familiarity with the young people in the unit. This collaborative relationship between the sexual assault service and the residential care unit might act as a minimum service enhancement.

The Report’s Second Recommendation suggests that every residential care unit should have access to a CSO specialist practitioner with expertise in sexual assault and sexually abusive or problem sexual behaviours. The expert practitioner would be involved in responding to and coordinating care and support for a child following an allegation of sexual abuse in care, particularly where children might be reluctant to seek external counselling. It is envisaged that the expert practitioner could also play a preventative role through provision of sexual health education to children and development of prevention strategies for children and staff with the aim of keeping children safe from sexual abuse and exploitation (p.20). This model has the advantage that the practitioner would be familiar to the child, forming part of their ongoing care team.

This issue is extremely critical, as young people residing in out-of-home care have repeatedly stated that what they would value most of all is having one stable person in their life. Instability is something that characterises the out-of-home care experience for very many young people, as they regularly move from placements and units employ agency staff. To achieve greater stability, the care workforce would need to become more professionalised with improved qualifications, training and experience, and supervision by practitioners with expertise, which is outlined in Recommendation One of the Report.

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?

In addition to the elements discussed above, those who are victims and survivors need to be assured that they can attend timely counselling. Children may not have disclosed experience of sexual abuse, but may demonstrate behaviours that are indicative of this and access to counselling is essential. If children are removed from their parents’ care due to physical and/or emotional abuse, then professionals should be attuned to the likelihood that such an environment is more likely to have enabled sexual abuse to occur also. If it is reported and investigated, then referral for counselling should occur as soon as possible. The work of the Commission through Taskforce 1000 suggests some children and young people have been waiting for up to five years for counselling.

There is also need to accept that children and young people should receive counselling and other support services as long as they require them, and that the imposition of time limits can be quite counterproductive. There is a recognised pattern that survivors of sexual assault are very likely to need to receive episodes of counselling and support throughout their lives, when they are experiencing vulnerability as a result of being traumatized again triggered by particular events or other stimuli.

An issue that is under recognised is the damage caused by those working in the industry having low aspirations for children and young people in out-of-home care in particular. Whilst it is appropriate to ensure professionals employ trauma-informed practice when working with these young people given their experiences, this should not lead to a consequent lowering of expectations in relation to educational progress, emotional and social development, behaviours and health outcomes. Young people should not be judged if they are not able to manage to achieve these aims, but they should be supported and services adapted, such as the use of customised educational settings, to reach their highest potential and for professionals to be very conscious of not having low aspirations for these young people and adopting innovative methods to support them.

The Report has also noted that there is an absence of suitable placement choices when placing a child in an out-of-home care placement. This is particularly true for Aboriginal children given the scarcity of residential care units operated by Aboriginal Community Controlled Organisations (ACCOs), despite the large over-representation of Aboriginal children in residential care. It is well known from experience that placing Aboriginal children away from their family and community leads to further isolation from cultural and support networks. This in turn leads to greater disconnection, and places them at higher future risk of suicide, mental illness and incarceration. Given the importance of cultural connectedness as a factor in resilience, it is
vital that this is preserved for children in out-of-home care (p.12) as the increased isolation resulting from a lack of cultural connection would further decrease the resilience of victim/survivors of child sexual abuse.

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?

The Report contains a quote which sums up the intrinsic difficulty for young people in out-of-home care, a young woman had said 'I don't feel special to anyone' (p.4). This young woman has powerfully articulated the experience of an absence of psychological parenting which is the vital, but unacknowledged role of a guardian.

Whilst the legal guardianship of a young person in out-of-home care might be with the State or a parent who is unable to provide for their daily care, the young person does not have an anchor-point in the world that reassures them that someone cares enough about them to remember their birthday and celebrate this and other occasions of significance. Unless the young person is able to form a relationship with someone who genuinely cares about them, it will be very difficult for them to be able to express what they need and for advocacy to support this. Whilst it may be possible for a professional to develop such a relationship with the young person, there will be ethical and professional conduct considerations that can make this challenging. There is also the practical difficulty that a professional will only be part of a young person's life on a time limited basis, other than in exceptional circumstances. The young person needs a significant other in their life who they can call upon during times of difficulty and celebration.

Carers of children in out-of-home care need training and guidance on how they can access services and support the child or young person. These individuals may be family, kinship or foster carers and they will need to respond on a daily basis to presenting behaviours of the victim/survivor.

Aboriginal and Torres Strait Islander children also need to be able to access culturally safe places for therapeutic responses. A comprehensive workforce plan to increase the participation of Aboriginal people in the field through scholarships, retraining and support roles is necessary. There is the potential to achieve this through leveraging off the already strong Aboriginal Community Controlled Health Services throughout Victoria and Nationally.

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?

It would seem that there may be quite some inconsistency in how well advocacy and support and therapeutic treatment services currently respond to the needs of secondary victims and survivors, such as family members, depending upon the nature of the service and funding arrangements.

For those young people in out-of-home care, there is a need for a clear protocol for a professional, such as the visiting sexual assault professional or expert practitioner discussed previously, to undertake a scoping audit. The audit would describe who might be viewed as potential secondary victims including family members, other staff or professionals, residential care clients or friends of the young person, and anyone else affected by the sexual abuse incident. The protocol would need to ensure that the young person's guardian was informed, which would require clarity about the young person's guardianship status.

It seems likely that on some occasions when the parent has retained legal guardianship of the young person, they may not have been very aware that a child sexual abuse allegation has been made. When a parent is made aware of this information, it must be done in a sensitive manner given there is an increased likelihood that it may trigger memories of their own abuse history and compound the guilt they feel about having a child in care. Given these circumstances, it is unsurprising that services find families will often have a long term engagement with them.

**Topic B: Diverse victims and survivors**

1. What existing advocacy and support and/or therapeutic 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?
In addition to the out-of-home care population, it would seem very likely that the rates of sexual assault of Aboriginal children in at-risk populations (such as those involved with Child Protection or Youth Justice services) may also be much higher than for non-Aboriginal children. For example, the NSW Ombudsman’s report of December 2012, “Responding to Child Sexual Abuse in Aboriginal Communities” states that in a 2002 survey of Aboriginal women incarcerated in NSW, 70% of the inmates reported that they had been previously sexually assaulted as children. Yet only a minority of the women who had been abused (20%) had previously told someone about the abuse and at least 68% of all survey participants said that they still required support or counselling to deal with these issues. The Ombudsman’s Report confirmed that there is an absence of appropriate services for incarcerated adults who make disclosures of child sexual abuse, and an absence of an appropriate supportive response when such disclosures are made.

In general, it seems that there is much work to be done to provide for the specific needs of diverse victim and survivor groups, with a current lack of appropriate models and innovative approaches being used to address the needs of at-risk populations.

For Aboriginal and Torres Strait Islander people, it is important that the service provides a welcoming and culturally safe environment including staff who are culturally sensitive and have regular training with Aboriginal trainers to increase their cultural awareness, as well as a workforce development plan that includes recruitment and training of Aboriginal and Torres Strait Islander staff.

The sexual assault support services report that they do seek to provide a welcoming environment with culturally appropriate artwork and undertake cultural competency training every two years as part of their workforce development program. Some services also have the benefit of being able to participate in cultural competency training that is provided as part of their role within major health networks. Different services also have collaborative arrangements with local Aboriginal services, such as assertive outreach to the Lake Tyers community from Gippsland CASA, the Worawa Aboriginal College in Healesville with East CASA, SE CASA and the Dandenong and District Aborigines Co-operative Limited. The services also work with the Aboriginal Legal Service and Aboriginal Liaison Officers such as those in the Royal Children’s Hospital and Monash Medical Centre.

The specific needs of those from CALD backgrounds are likely to be influenced by the length of time since their arrival in Australia. The nature of their experiences prior to arrival will also dictate the type of services required, with those from asylum seeker and refugee backgrounds likely to have been exposed to torture and trauma during their journey. To effectively work with these populations, service staff need to have cultural knowledge and insights regarding the social mores of the group and be able to conduct a dialogue around the broader community’s expectations which may also involve legislation. For example, forced early marriage and female genital mutilation (FGM) are issues that the broader community are largely unfamiliar with and may be quite commonplace within some cultural groups, which service staff need to respond to. The service needs to provide a welcoming environment with the use of cultural artworks and resources in a range of community languages. Sexual assault services provide such materials and training in working with interpreters and include cultural competency training as part of the workforce development. Services have developed partnerships with local cultural groups such as those in the Mallee and Shepparton areas, and with the local Migrant Resource Centre. The services also regularly receive invitations to speak to local community groups about sexual assault and Australian values, which provides an important opportunity for cultural information exchange and relationship building.

Those from LGBTI communities also require services to be inclusive, by removing an assumption that all service users are heterosexual and placing a range of options in relation to gender on intake forms. Service staff should also demonstrate knowledge of LGBTI relationships and sexual practices, and ensure that victim/survivors will not experience a homophobic or heterosexist response when seeking to access services. Young people especially may be afraid of being ‘outed’ to friends and family and the experience of sexual abuse may raise complex issues regarding their sexuality, possibly including internalised homophobia, that professionals should be able to confidently explore. There are likely to be particular difficulties in rural and remote areas where same-sex relationships and gender diversity may not be tolerated and fear of outing may be especially acute, combined with a lack of LGBTI support services and networks. At the current time, sexual assault services provide support to LGBTI clients as part of the general client group. Services may include promotional material indicating they provide a ‘gay friendly’ service and employ male counsellors to provide diversity in service response, and there are also groups for young people which include themes on
gender identity. The respectful relationships programs also seek to provide avenues for young people to explore and disclose experiences of abuse.

Victim/survivors with a disability may experience added difficulties in accessing advocacy and support services, whether they have a physical disability or mental impairment. Those with disabilities are more vulnerable to abuse, with rates of sexual abuse estimated to be twice as high in the population of those with disabilities. Support services need to be accessible for those with mobility impairment and service delivery adjusted for those who require communication aids. Staff who provide care for those with disabilities, whether in residential or educational settings, need specialist training on the behavioural indicators of sexual abuse and guidance on how to work collaboratively with sexual assault services. Caring staff can also provide sexual assault service professionals with assistance on how to most effectively work with those with disabilities. For example, sexual assault services work closely with special schools to support their students. SECASA has been involved in the Making Rights Reality Program which supports adults who have been sexually assaulted and who have an intellectual disability or an Acquired Brain Injury or use aids to communicate. The materials are provided in the form of Easy Read brochures to support victim/survivors in how to access services.

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?

In addition to the perennial problem of a lack of Aboriginal counsellors, due to issues such as workforce development, training, accreditation and supervision of staff, and sessions may need to be in an Aboriginal language, as English can be a second or third language in regional and remote communities in Australia, there may also be difficulties with the usual models of counselling not being appropriate for use with Aboriginal clients for whom stigma may be attached to participating in therapy. These models may not be respectful of cultural needs, including reservations that Aboriginal people may have about discussing sexual matters in direct terms, especially with a member of the opposite sex. In many Aboriginal communities, learning and healing occurs in the presence and through the interest of the group or community, rather than the individual. Similarly, some Aboriginal people may prefer not to access services within their community as confidentiality may be an issue (O’Brien, 2010). The Department of Health and Ageing has identified that there can also be complexities inherent in providing both protective and therapeutic services in an atmosphere of trust and support, when the intergenerational trauma of past forced removals of Aboriginal and Torres Strait Islander people has negatively impacted entire communities.

In the “Breaking the Silence” report, ACSAT (Aboriginal Child Sexual Assault Taskforce) highlighted the perceived limitations of the criminal justice system in responding to Aboriginal child sexual assault, including high rates of recidivism, a lack of effectiveness of sex offender programs and negative experiences of victims in the legal process. It was proposed that the Community Holistic Circle Healing process developed in Hollow Water, Canada, a restorative justice model for addressing child sexual assault could be adapted to suit Aboriginal communities in NSW. The model is based on a “community wide” response, with a team established to support the child and immediate family, and another team working with the offender. This is a court sanctioned rehabilitation program and whilst the offender continues in the program, and/or successfully completes the program, no other criminal action is taken.

Please also see the discussion above responding to question B1.

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

A major difficulty for those victim/survivors in correctional institutions is the need for a safe environment in which to disclose experience of sexual abuse. These settings are associated with aggressive and violent behaviour including sexual assaults given their inherent nature. It would also be expected that a very high percentage of these populations have experienced sexual assault in their lives (as confirmed in the NSW Ombudsman’s Report cited above). Thus it is critical that clear policies and procedures are in place to promote disclosure of historical or current sexual abuse, and that victim/survivors can have confidence that allegations will be investigated thoroughly and offenders held to account. It is essential that the relationship between sexual abuse trauma and drug and alcohol use and mental health issues is well understood by both custodial staff and support services dealing with the victim/survivors to ensure they receive the full suite of services they need.
A protocol for provision of support from the local sexual assault service when disclosures are made is required, as well as a system for handover to the individual's local provider for follow up counselling upon their release. At the current time, WestCASA provides support to the Dame Phyllis Frost Centre, a correctional institution for young and adult women. The Gatehouse Centre at the RCH provides support to the SWS (Secure Welfare Service) providing a weekly group session, and SECASA provides a specialist group for young people who have been sexually exploited. The YHARS (Youth Health and Rehabilitation Service) has provided health services for Parkville Youth Justice Precinct, Melbourn Youth Justice Precinct and Secure Welfare since 1 January 2014. Whilst the Youth Justice Custodial Practice Manual outlines procedures in relation to Mental health treatment, Professional behaviour and boundaries and Contacting the police which all contain material in relation to sexual assault, it would seem useful if this could be consolidated into a single procedure that is clearly identified as Sexual abuse.

For example, whilst the material included in mental health problems covers signs and symptoms, there is no mention that many of these are behavioural indicators of sexual abuse, and the close linkage between sexual assault and mental health issues. There is also material that outlines procedures to follow for investigation in the event of staff becoming aware of an alleged sexual assault, but there does not appear to be comprehensive guidance on how to immediately respond if a young person discloses or appears likely to disclose sexual assault, particularly if this is historical in nature. Similarly, the Checklist – conducting an unclothed search with young people aged 10-14 years includes a question under Risk Factors regarding whether the young person's known history of sexual abuse or sexual assault may cause significant concern in carrying out an unclothed search. But it is unclear what should occur if a positive response is elicited for this question and under what circumstances there would be any likelihood of a negative response to the question. To make this assessment, custodial staff would need quite a degree of clinical training and access to a detailed therapeutic history of the client, which would seem unlikely to be the case.

**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)?

People living in rural and remote areas are disproportionately affected in terms of access to services which are more restricted in these areas due to geographic isolation. There is often limited or no public transport for victim/survivors to be able to get to major centres, requiring that counsellor/advocates travel to smaller towns to provide an outreach service.

This means that the counsellor will often spend a great deal of time travelling for what may be a single appointment, which would continue to be the problem if mobile services with a visiting specialist counsellor were utilized. The alternative of providing travel assistance to clients has limited validity in that many clients may not own or have access to a vehicle or have a license to drive, especially those who are too young.

The population may also be more transient due to limited employment opportunities and a lack of affordable housing, including access to public housing. Complexity in service delivery can also result from cross border issues when multiple jurisdictions are involved and there are differing criminal justice responses between the States and Territories. The density of relationships in rural communities can also pose a barrier to clients when they disclose, as the local police and community members may have difficulty accepting that a perceived "good" person known in the community is an alleged offender, they may also be faced with staff who are related to themselves or the perpetrator.

Service provision to victim/survivors in rural and remote areas also requires extra sensitivity regarding confidentiality and anonymity. For example, the counsellor/advocate may do outreach to the local community health centre, where the receptionist is known to the victim/survivor. For this reason, some clients may prefer to access this specialized counselling outside their local area. Privacy can also be a particular issue in relation to the provision of the more limited interpreting services for CALD communities, who may also be over-represented in rural areas. More recent immigrants may also be without the same rights or economic and social supports as other community members, with citizenship status having significant implications for the range of supports and services that a community member can access.

2. What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?
The innovative ways to overcome the geographical barriers to providing and receiving support for victim/survivors are primarily dependent upon use of technology such as provision of online counselling via Skype. There may be a need in some cases to financially support clients to access the appropriate technology and some problems have been encountered with a lack of reliable internet services being available in some rural and remote settings. For example, only 20 kilometres outside Wangaratta does not have access to broadband and if satellite is used instead, the cost is three times that of accessing such services in townships. The Centre Against Violence (CAV) in Wangaratta and CASA Forum have worked together to prepare policy and practice guidelines which include instructions clients can use to ensure the content is secure and safe.

It would also be helpful if witness evidence facilities could be provided within the Multi-Disciplinary Centres (MDCs) and there was improved access to legal information and legal representation in relation to family court and children’s court matters.

**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?

Counsellor/advocates at sexual assault services have observed that clients generally do not like being labelled as either “victims” or “survivors”. Clients have suggested the alternative terms of “children, women and men who have experienced sexual assault/abuse” or are ‘dealing with the impacts of sexual assault/abuse’, but these terms are perceived as quite awkward for everyday usage.

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?

There is a continuum of service delivery provided for victim/survivors which commences with provision of crisis care, support and advocacy (telephone and face-to-face), therapeutic counselling interventions (both individual and group) offered by sexual assault services to respond to needs. The models of service provision can be tailored for particular target groups such as children, young people, adult women, adult men, parents, partners, Aboriginal people, members of CALD communities and those with disabilities. The Making Rights Reality Program at SECASA, which works with clients who have been sexually assaulted and have a cognitive disability and perhaps an acquired brain injury and may use communication aids, is an example of this.

There is statewide provision of crisis care for victims up to two weeks following a sexual assault ensuring there is a fairly immediate response. The service system responsible for this response involves collaboration between each regional CASA, the statewide after hours sexual assault crisis line, the local Victoria Police Sexual Offences and Child Abuse Investigation Team (SOCIT), hospital emergency departments and the Victorian Institute of Forensic Medicine (VIFM). This systemic response is governed by a range of protocols, including *the Police Code of Practice for the Investigation of Sexual Assault*, which was first established in 1992 and has been reviewed since. Strong relationships between the organizations support the implementation, fostered through initiatives such as the quarterly liaison meetings held between police and CASAs in each region.

When children and young people are victims of sexual assault and there are protective concerns, a systemic response will be required to ensure their safety, in addition to therapeutic interventions to reduce the impact of trauma. Development and careful nurturing of the relationships between the CASAs and the child protection service in each region will ensure this is a collaborative response. In those locations where there is a Multi-Disciplinary Centre, the collaborative relationships between the CASA, SOCIT and Child Protection are well developed through their co-location and work together. An unpublished PhD thesis, *Evaluation of Victoria Police SOCIT-MDC reforms for sexual assault investigation*, suggests these reforms have led to improvements, including faster police investigation times (Darwinkel, 2014).
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?

It is critical that practitioners who provide advocacy, support and therapeutic treatment are appropriately qualified and experienced. Sexual assault services employ staff with tertiary degrees, usually in social work or psychology and often with additional postgraduate counselling qualifications. Whilst relevant counselling experience is also important, the services are able to provide orientation, supervision and training to staff to enable effective provision of these specialist services. Sexual assault services also have a commitment to providing individual supervision for counsellor/advocates, usually by senior clinicians and team leaders. Access is also provided to relevant, contemporary professional development across the sector through the DHHS Funded Workforce Development program. Counsellor/advocates are also encouraged to access other external professional development opportunities such as those provided by visiting international experts.

The provision of trauma counselling and other services in the context of a staff team where there is peer support is also important for the wellbeing of counsellors to ameliorate the impact of vicarious trauma resulting from the provision of sexual trauma counselling.

Sexual assault services also provide student placements for those completing relevant training, which resources a larger range of professionals who have experience of providing therapeutic trauma counselling and may assist in enabling people from diverse groups to access employment in this area. The promotion of best practice approaches for working with people who have been sexually assaulted is also supported through sexual assault services providing secondary consultation and training to a range of other professionals. The training workshops include "Responding to disclosures of sexual assault" and "Working with adults/children who have experienced sexual assault".

**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?

Restorative justice is a practice that the CASA forum members have been prepared to offer. This is a service option located outside the legal sector and is available at SECASA and the Gatehouse Centre, and will commence at the CAV in Wangaratta in 2016. The restorative justice movement has developed over the last 20-30 years and has a substantial evidence base to support its work. Restorative justice has the capacity to offer victim/survivors the experience of being heard and of receiving justice through the validation of their experience, promoting outcomes that enhance recovery. The Victorian Association of Restorative Justice (VARJ) has adapted Best Practice Standards that enable local practitioners to work to international standards. These standards can be found on the website at [www.varj.asn.au](http://www.varj.asn.au)

There are also many therapies that have been developed for use with survivors of sexual assault, including those that have a basis in trauma theory, such as *Trauma informed acceptance and commitment therapy* and *Accelerated trauma recovery ‘Mandala’ therapy*, solution focussed and narrative therapy and mindfulness. There are also emerging therapies that are not reliant upon talking in the counselling room and enable those who have experienced sexual assault or other forms of trauma to have daily 24 hour support, such as canine or equine therapies. For example, a trained therapy dog will wake up a person who is experiencing a nightmare, thus enabling them to reduce intrusion. The therapy dog will accompany the person in the same way that a guide dog does, and will notice and respond to panic/anxiety attacks. Equine therapy is an engaging form of intervention which enables clients to work on themes such as trust and acceptance through an experiential approach with a horse. There are also a number of innovative arts based therapies such as play and expressive arts therapy, reflexology and gym groups.

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

Restorative justice practices have been extensively evaluated and some of the results can be found in the conference papers on the VARJ website [www.varj.asn.au](http://www.varj.asn.au). The impact of reflexology and the gym group have also been evaluated positively with findings held at SECASA.
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?

This is covered above.

Yours sincerely

Bernie Geary OAM
Principal Commissioner

Andrew Jackomos PSM
Commissioner for Aboriginal Children and Young People

References


Commission for Children and Young People (CCYP) (2015). "...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care. Commission for Children and Young People.


Ombudsman NSW (2012). Responding to Child Sexual Assault in Aboriginal Communities. Ombudsman NSW.