



**GIPPSLAND**  
Centre Against Sexual Assault

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

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## GCASA

**Vision:** *To see our communities free of sexual assault and violence*

**Mission:** *To enhance safety and quality of life throughout the Gippsland region by reducing the incidence and impact of sexual assault*

**Values:** *The work of Gippsland Centre against Sexual Assault and its team members is underpinned by the values of*

- **Empowerment**
- **Respect**
- **Dignity**

Gippsland Centre against Sexual Assault (GCASA) is funded by the Department of Health & Human Services, Victoria. It is managed by an incorporated community-based Board and is funded to provide comprehensive sexual assault support services and sexually abusive treatment services across the Gippsland region (Health Region 5), which extends from Bunyip River to the NSW border at Mallacoota, and from the Great Divide to the sea, including Phillip Island. The primary offices are in Morwell and in Bairnsdale. Outreach sessions are offered in Orbost, Sale, Leongatha and Warragul.

The Agency operates within a framework that actively supports the protection of the rights, integrity, autonomy and dignity of women, men and children who have experienced recent or past sexual assault.

GCASA also provides support to their families, carers and other support networks that may include information, resources, counselling and group work. The Agency provides consultancy and professional training for other workers to increase professional knowledge about the incidence, causes and effects of sexual assault, and to develop skills in responding sensitively to people's needs and concerns. The Agency provides assessment and treatment for children demonstrating problematic sexual behaviour and to young people who are demonstrating harmful sexual behaviour.

GCASA works within the broader community in order to reduce the incidence of sexual assault and to improve general understanding and appropriate response. Community development activities to promote social inclusion within and across marginalised groups are an integral part of the organisation's mandate.

## Introduction

Gippsland Centre against Sexual Assault (GCASA) is pleased to be able to contribute to the consultation process for the Royal Commission into Institutional Responses to Child Sexual Abuse - Issues paper 10: Advocacy and Support and Therapeutic Treatment Services. GCASA is able to comment in relation to direct service provision relating to people who have experienced sexual assault, and children and young people displaying sexually harmful behaviours.

There are two global points we would like to make; the importance of language and the contextualisation of violence. We believe that a culture supporting violence can be legitimised through the, often unconscious, use of language. Victim blaming is an obvious example. We have made a conscious decision to ensure language reflects violence as an external event that does not define people. This is both from a victim and offender perspective. Examples include “people who have experienced sexual assault” and “people engaging in violence.” This is consistent with psychological theories of identity constructs and supports wellbeing through implying opportunity for change and not labelling people through their experiences of trauma.

It may be useful to consider the construct of sexual assault more broadly through the lens of social inclusion/ social exclusion, and, as well, recognise that violence occurs both directly and indirectly, and is often constructed within the strata of this country’s culture.

The journal article ‘Social Exclusion, Refusal and the Cycle of Rejection: A Cynical Analysis’ (Scanlon & Adlam 2008) explores the issue of homelessness however, the points that are made may, as well, be applied to the issue of childhood sexual abuse.

James Gilligan is referenced, arguing that

“...societally we have a need for there to be victims of violence, power differentials and relative deprivation in order that ‘we’ can have a more secure sense of our own well-being in relation to ‘them’, the dis-eased. This ordinary violence, rooted in the humiliation inherent in the relative poverty of the dispossessed, is then perpetrated in the large groups and communities that we have co-constructed. We can only really understand the reason for much behavioural and social violence by thinking how humiliating it is for people to live in relative poverty compared to their near neighbors...” James Gilligan maintains that it is impossible to understand individual acts of violence without understanding this relationship between the haves and the have-nots, or to understand violence and dangerousness except in terms of those who have previously experienced themselves as endangered and violated within a shameful, disrespectful and offensive society” (in Scanlon et al, p 534)

While as a country we speak the language of affirmative inclusion, we are perhaps not as yet able to consider the concept of social inclusion/ social exclusion through a transformative lens as well. That is an affirmative and transformative inclusion lens that recognises the connections between social justice, social constructs, social inclusion/ exclusion and structural violence.

Affirmative politics merely involves the surface transfer of resources without changing the basic underlying divisions whereas transformative politics seek to eliminate the basic underlying structures of injustice (Mooney, J. 2000).

Affirmative remedies involve, for example, coercing the underclass (read marginalised) into the labour market at extremely low wages. Their position is merely reproduced this time within the lower reaches of the market place.

An affirmative politics of recognition does not question the various essentialisms of difference. That is, in the case of conventional multiculturalism, what is stressed is the need for the positive recognition of various groups on equal terms, for example: Irish, African-Caribbean, Gays, Women, etc. In contrast, **transformative politics** seek to break down and destabilise the categories by questioning the very notion of fixed identity and essence. Thus the invented notion of tradition is challenged, the overlapping, interwoven nature of what are supposedly separate cultures stressed, and the ambiguity and blurred nature of boundaries emphasised. Diversity is encouraged and, where non-oppressive, celebrated, but difference is seen as a phenomenon of cultures in flux not essences which are fixed.

Sexual assault would not exist in this country in the dimension that it does without a parallel cultural structure that supports it. Consider the everyday throwaway line of our senior and minor public figures:- “that is a matter for them”. While not necessarily related to the issue of sexual assault, it is not unreasonable to surmise that this consistently reinforces what is now being termed the ‘bystander effect’.

Within the sexual assault service sector, and the wider community services sector, many workers themselves are indirectly ‘brutalised’ by the agency that employs them through lack of structural support within the program itself. This is not always down to lack of resources that would establish a framework of support within the program for staff persons. Services themselves are known to talk the ‘language’ of the ‘drama triangle’ (Karpman) , and often unconsciously are held within it.

Structural violence’, a term coined by Johan Galtung and by liberation theologians during the 1960s, describes social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential.

In its general usage, the word *violence* often conveys a physical image; however, according to Galtung, it is the “avoidable impairment of fundamental human needs or...the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible”.

Structural violence is often embedded in longstanding “ubiquitous social structures, normalized by stable institutions and regular experience”.

Because they seem so ordinary in our ways of understanding the world, they appear almost invisible.

Disparate access to resources, political power, education, health care, and legal standing are just a few examples. The idea of *structural violence* is linked very closely to *social injustice* and the social machinery of oppression” (Farmer, P et al, 2006).

Structural violence is the result of policy and social structures, and change can only be a product of altering the processes that encourage structural violence in the first place. Paul Farmer claims that "structural interventions" are one possible solution.

“The term structural violence is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities). With few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease”. (Farmer. P et al, 2006)

We are clear that what we have done previously has not worked, let us consider this issue differently in the wider cultural structure of this country.

“There can be little doubt that power is of overriding concern to human beings. It may be man’s most central concern...And the absence of power is terribly destructive. What some are accustomed to thinking of as the enduring debilitating characteristics of the poor- such as apathy, fatalism, depression, and pessimism- are actually the straightforward manifestations of the dynamics arising from a lack of power. Man powerless is not fully man” (Ryan, K. pp 251, 252).

“There are many and varied psychosocial equivalences that are exactly such places for people whose experience is one of actual humiliation and social exclusion. These places and appointments are made because such people do not yet have the capacity to communicate their disappointment more articulately and, because we for our part do not yet have the capacity to understand their offensiveness and refusal as both a cryptic and a straightforward publication of their distress, disturbance, disaffection and psychosocial dis-memberment”. (Scanlon et al, p 536)

As Scanlon et al suggest, perhaps we are not yet ready to embrace this as the implications upon and for ourselves are too great.

## **Topic A: Victim/ Survivor Needs**

GCASA has been operating for 27 years and has the benefit of working within the wider CASA state wide network with over 30 years of direct service provision experience. Over the years the model of service delivery has improved (and continues) through the reliance on research and client feedback/ outcomes. In summary this has a basis in feminist and human rights principles that consider the impact of trauma, gender, research, and systemic considerations. The services provided are essentially individualised intervention planning based on the unique needs of people. There has been, and continues to be, strong social justice underpinning to service delivery that is working towards equity in service delivery to assist populations that face additional barriers to service access such as people with disabilities, mental health issues and those from Indigenous and culturally diverse communities. This requires analysis of the barriers and unique requirements and service delivery adjustment within available resources.

People who have experienced sexual assault often need to navigate multiple systems such as legal, health, social, family, education and employment at a time when they may not be as able to access higher cognitive functioning due to neurological trauma responses (Van Der Kolk, 2008). Advocacy then becomes essential in supporting people. We have found the CASA model of counsellor/ advocate to be essential for this service provision, informed by the clinical work and knowledge of

the service systems. This component of the work can essentially reduce the length of service provision if able to respond in a timely manner. This is because fast pre trauma functioning restoration can mitigate psychological impacts and therefore therapeutic service provision. Advocacy is part of the work undertaken by CASAs however the funding model does not account for a full systemic response that ideally would include a fully developed case management component.

In addition to the systemic work mentioned, family work is an essential component. Whilst again that occurs to some degree in the current service system, in order to strengthen responses more emphasis on the family system could be provided. GCASA is currently piloting a Family Support Practitioner model to essentially work within the home environment, supporting families when sibling sexual abuse has occurred, through parental education on trauma, psycho education more broadly, safety planning and attempting to translate the therapeutic work to the family context. Family therapy is also currently not widely funded but an essential component to minimising the impact of sexual assault trauma. This could also be seen through broader lack of recognition of secondary “victims” or people not directly impacted, who however experience psychological / emotional injuries.

Other examples of systems work required are within education facilities (school, kindergarten). This could essentially be work around affect regulation and indirect supportive/ preventative work through psycho education. Looking broader at service delivery areas and how best to support other professional and community members dealing with sexual assault, a consultancy or supervision service could be of assistance and alleviate cross referrals and people falling through service systems. As an example the problem gambling counselling service and mental health services/ provision of psychological services would have very high percentages of people with sexual assault experiences. Support should be provided in a consistent way by managing the person’s individual needs. Sexual assault services could provide greater benefit to the community if they were able to provide supervision units to support the service systems through supervision/ consultation, supportive referral to appropriate service and community education to provide broader support, skills and confidence in appropriately responding to sexual assault. As an example a significant benefit could be coordination and support in transitioning from a service such as Better Access, where session restrictions do not equate to individualised therapeutic needs for complex trauma, and into specialist sexual assault services. Often this resource is not realised because the therapeutic plan does not account for the longer planning that may be required. Adults Surviving Child Abuse (ASCA) guidelines (Kezelman & Stavropoulos,2012) for the treatment of complex trauma refer to research demonstrating that the majority of people treated by mental health and drug and alcohol services misdiagnose complex trauma. Many people presenting for therapy regardless of the presenting issue would have trauma, often complex trauma, as the origin of the issues.

GCASA has recently undertaken a benefits’ realisation and break even analysis of the services provided through Deloitte Access Economics (2015; Deloitte Access Economics). This report is yet to be released however it conservatively estimates for every dollar invested into direct service, a return on investment of \$2.47 is provided back to the community. This figure does not calculate the benefits from systemic work which would inflate the value exponentially.

## **Topic B: Diverse Victims and Survivors**

As mentioned in Topic A, if we see people as individuals then a one size fits all approach can not be applied. This is helpful in interventions relating to diversity within our communities. As an example, we prefer to consider cultural sensitivity rather than competency. As a workforce we need to have broad understandings of cultures and identities and then apply curiosity to learn and appreciate the degree, aspects and meaning of acculturation for the individual.

At an organisational level it is important to look at data, statistics, research and community engagement to appreciate and understand the unique demographics and context of the areas to which we are providing services. This can help shape organisational and service delivery design in responding to barriers and gaps in service provision. GCASA has worked on a number of assertive outreach, informal “drop in” models that seek to support in an indirect way initially, supporting workers, and providing informal, everyday conversations with people that can and often lead to direct service delivery through the establishment of trust. Diverse populations often require a more community based approach. As mentioned in Topic A, service provision within places like kindergartens can also be a place of intersect for diverse communities.

It can be very helpful to have an established relationship with trusted community members/ elders to seek general support and guidance about issues specific to populations (cultural histories, lines of communication, barriers and community needs). Further to this point, and on a broader level, we have seen an erosion of the position of Public Advocate and Community leaders and elders appointed to government positions to demonstrate leadership and give a voice for diverse and often discriminated populations. An example of the power and symbolism of this is the public apology of “sorry” to aboriginal people.

Broader systems’ considerations and culturally responsive planning and service delivery for people leaving institutions (detention centres, prisons, mental health facilities etc) should be viewed through a trauma informed lens of looking at the “whole story” for people and their experiences. Planning needs to consider the developmental, cultural, trauma and social psychology, in the transitioning in and out of these environments. An example may be that of service provision feeling unsafe for someone within a building, and therefore inhibitive to trauma informed practice. Another important element is that our structures and policies, set with the best intent for safety, are often counterproductive. An example is the assumptions of people based on history/ conviction of violence. The structures often are an antagonist to the capacity for people to change and therefore restrict access to services that may in fact be the tool or catalyst for prevention. If a person has been sexually assaulted and then commits sexual offences, they can be excluded for service delivery on the basis of safety- again a form of structural violence. Safety planning at the point of referral and an individual intervention would address issues.

Anyone seeking a therapeutic service does so at a point when they need an intervention. The importance of responsive service delivery is essential. Diverse populations also have additional barriers to overcome to reach that point, such as racism, access points, and cultural communication lines to name a few. This makes engagement and responsivity critical otherwise it can become a lost opportunity and increase psychological pain and isolation. An example is young people- lost opportunities can also contribute to dysfunctional developmental stages leading to future issues for

that person and the system needing to support them. In our sector waiting times are problematic and future modelling suggests this will increase as demand increases without structural changes.

### **Topic C: Geographical Considerations**

Rural and regional areas are typically characterised by complex layers of social disadvantage and issues. (Pope, 2011; Vinson et al, 2015, also see SEIFA data) The problems, disadvantage and discrimination are further impacted by issues faced in these areas such as isolation, lack of relevant/ specialist services, travelling distances, limited opportunities, confidentiality concerns and socioeconomic situations.

In providing timely service delivery these characteristics impact on resources allocation through the cost and availability of outreach offices, staff travelling time and visibility in terms of protection of confidentiality. It can also be difficult at outreach sites to have the flexibility of another counsellor (should a conflict/ dual role situation arise), provide different counsellors to family members (such as sibling groups) and offer appointment scheduling flexibility. Funding models do not appear to take this complexity into consideration.

Technology offers some options such as the telemedicine model using Skype for counselling sessions in remote areas however this is dependent on access and quality of the internet. The internet currently provides a level of social and supportive networks however face to face contact is important. The possible inclusion of videoconferencing within the Multi Disciplinary Centre (MDC) model provides opportunity for witness evidence within courts that would extend opportunities of supportive and confidential environments for this to occur. This technology could also assist in accessing other specialised services not currently available. Any progression in this area needs careful consideration as a balance of having access to the services in a metro centralised manner should not come at the expense of opportunities for face to face access through regional provision of service. This could further disadvantage people, as a direct, in person experience of a service, is a far richer experience which translates to better outcomes.

Strategic alliances need to be developed around points of interaction that provide opportunity for intervention and support. Links with General Practitioners are one example and are critical.

### **Topic D: Service Systems Issues**

The service system can be complex for people to navigate. Difficulties increase when someone has experienced trauma and may have impaired ability to access higher cognitive thinking. Another significant impairment is that often sexual assault services have limited profiles within the wider community as people have found the issues and topic difficult to acknowledge.

Any model that can provide integration of complex service systems, that practises from a trauma informed framework, covers the breadth of specialist areas, and has processes in place to minimise/ streamline people's contact unnecessarily, reduce the risk of falling through service system gaps and the need to repeat traumatic narratives, would be beneficial. The MDC model in Victoria is one such example with the inclusion of therapy, advocacy, policing, health and legal services. Positive outcomes have been achieved (Success Works 2008, 2010) and ongoing evaluation is occurring.

A significant gap in the service system is the inability to sufficiently fund family therapy and/or models such as multi systemic therapy. These interventions can influence change in environments that have the capacity to support/ not support people who have experienced sexual assault. Programs such as the Sexually Abusive Treatment Programs (funded by DHHS Victoria) use a funding model that considers the systemic work required. This program has been evaluated with positive outcomes (Synergistiq, 2013). This work is important in the sexual assault sector because it firstly sends a de-pathologising message that these issues may be within an environment that supports, or not supports, people's functioning. Secondly, regardless of psychological functioning people are not isolated in their recovery, and thirdly, people not directly impacted (secondary victims) are supported. This is important in recovery for these people in their own right, and also to facilitate recovery for the people that experience sexual assault. Relational transactions are central to trauma informed practices both at an individual level and across and within the systems in which that individual sits. Ideally a service provision to those indirectly impacted would become normative and automatic for assistance in their own right. Finally, working in this way, educates the community in a broader sense about sexual assault, how to respond and support. This will inevitably have ripple effects into prevention and community responsibility.

Advocacy is an area that is often unrecognised in funding models however the importance of this is critical in trauma recovery. Often this is all that people need and thus reduces the demand on therapeutic service delivery if provided in a timely manner. This is evidenced in the large body of research and practice from the critical incident debriefing area (psychological first aid, mental health first aid). Systemic advocacy, that is advocacy at a macro level that looks to influence change in the systems designed to prevent and respond to sexual assault, is again often not included in funding models. As an example peak bodies like CASA Forum ideally would have a funded position supporting this work in the form of a policy officer or secretariat. This work is currently facilitated by managers in addition to their organisational responsibilities and duties

## **Topic E: Evidence and promising practice**

The following promising, and established, practice models have been discussed within this Issues Paper for their usefulness to the sexual assault sector:

- The MDC model of service provision
- Family therapy
- Multi systemic interventions and/ or models
- Sexually Abusive Behaviour Treatment Services and the systemic funding model
- Advocacy

In addition, it is worth mentioning somatic processing techniques that people provided with a GCASA service find helpful. Increasingly research demonstrates neurobiological processes that impact on people's ability to create language around trauma and therefore for some people top down trauma processing (talking/ cognitive therapy) will not work. Instead, bottom up processing can assist through somatic work such as trauma informed yoga and many other forms of somatic processing. Again, this reinforces the need for individualised interventions.

Many CASA managers and staff members have been trained or exposed to Restorative Justice Models. This model is well researched (Rugge et al, 2005; Daly, 2011) in areas other than sexual assault however at least two CASAs are piloting these programs. It is known through service provision that this model would be useful either as a stand-alone intervention or within a package of complementary interventions.

GCASA has been involved with a program for people with an intellectual disability designed to provide education and discussion about respectful relationships called Living Safer Sexual Lives. This program utilises a peer educator/ co-facilitator model developed by Dr Patsie Frawley (Frawley, Barrett & Dyson, 2012) and has positive outcomes.

## **Key Messages**

- This is a time of great opportunity
- The wider community are part of the solution, we need to support this
- Structural violence needs to be considered and addressed
- Men are not the problem, male privilege and gender inequality are- these need to be addressed at a structural level

## References

- Daly, K. (2011). Conventional and innovative justice responses to sexual violence, *ACSSA Issues*, 12
- Deloitte Access Economics. (2015). *Benefits realisation and break even analysis of services provided by the Gippsland Centre against Sexual Assault* (yet to be released)
- Farmer, P.E. et al (2006). *Structural Violence and Clinical Medicine*. *PLoS Med*3 (10):e449, doi.101371/journal.pmed.0030449
- Frawley, P., Barrett, C. & Dyson, D. (2012) *Real People Core Business. Living Safer Sexual Lives: Respectful Relationships. Report on the development and implementation of a peer led violence and abuse program for People with Intellectual Disabilities*. Melbourne, Australia Research Centre in Sex, Health and Society, LaTrobe University
- Galtung, J. (1969). *Violence, Peace and Peace Research*, *J Peace Res* 6:167-191
- Kezelman, C & Stravropoulos, P. (2012). *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA)
- Mooney, J. (2000). *Gender, Violence and the Social Order*, Macmillan/ Palgrave (Hbko-333-73480-7, Pbk 0-333-91886-x)
- Pope. J. (2011) *Change and disadvantage in the Gippsland Region, Victoria*, Department of Planning and Community Development
- Rugge, T., Bonta, J. & Wallace-Capretta, S. (2005). *Evaluation of Collaborative Justice Project: A Restorative Justice Program for Serious Crime*
- Ryan, K. (2007). *Social Exclusion and the politics of order*, Manchester, Manchester United Press
- Scanlon, C. & Adlam, J. (2008). *Refusal, Social Exclusion and the Cycle of Rejection: A Cynical Analysis*, *Critical Social Policy*, 28(4).
- Success Works. (2008). *Sexual Assault Reform Strategy: First Evaluation Report*, Department of Justice
- Success Works. (2010). *Sexual Assault Reform Strategy: Second Evaluation Report*, Department of Justice
- Synergistiq. (2013). *Evaluation of the Sexually Abusive Behaviours Treatment Services*, Department of Human Services

Van der Kolk, Bessel. 2000. *Posttraumatic Stress Disorder and the Nature of Trauma, Dialogues in Clinical Neuroscience* 2 (1): 7–22

Vinson, T., Rawsthorne, M., Beavis, A., & Ericson, M. (2015). *Dropping off the Edge 2015: Persistent communal disadvantage in Australia*, Jesuit Social Services