

Royal Commission into Institutional Responses to Child Sexual Abuse

Submission to Issues Paper 10 Advocacy and Support and Therapeutic Treatment Services

By Mark Griffiths

My background and experience

My name is Mark Griffiths and I am a Psychologist working part-time in private practice.

- I retired from full-time employment in July 2009 as a Senior Psychologist employed at the Eastern and Central Sexual Assault Service at Royal Prince Alfred Hospital Sydney.
- At the time of my retirement I was Deputy Manager of the service and job sharing in the Manager's role.
- I commenced employment in the Sexual Assault Service in November 1997. Prior to this I was employed within Central Sydney Area Health Service at Newtown and Redfern Community Health Centres where I worked as Psychologist and subsequently Team Leader.
- Apart from my part time private practice I am also the Chair of the Clinical Advisory Board of **Survivors and Mates Support Network (SAMSN)**, a group supporting men who were sexually abused as children.
- My formal qualifications are Bachelor of Arts (Honours Psychology), University of New South Wales.
- I am registered to practise as a Psychologist (Reg No PSY0001137420) and I am a member of The Australian Psychological Society.
- I am a Registered Medicare provider as well as an Approved Specialist Counsellor for NSW Attorney General and Justice, Victims Services. In this latter role I provide counselling for victims of crime, in particular those who have been sexually abused as children.

My first involvement with adult survivors of child sexual abuse was at Newtown Community Health Service. Initially this was with female survivors and I began seeing male survivors in 1990. In response to a client's request and with the assistance of a colleague Tony Phiskie I set up a group for male survivors (The Men's Support Group) in 1991. These groups continued during my employment at Newtown and subsequently at the Eastern and Central Sexual Assault Service at Royal Prince Alfred (RPA) Hospital. Upon my retirement from RPA in 2009, the groups unfortunately ceased because there was no longer a male employed in that service.

In 2011 the directors of SAMSN approached me with the request to begin groups for male survivors. As a result the groups have continued broadly

following the original format. **Addendum 1 Table 1** summarises statistics for the groups held in the three organisations and the numbers who have attended.

To date SAMSN has received no Government funding to support the day to day running of the organisation. However NSW Victims Services pay for those men who were assaulted in NSW to attend the groups. SAMSN's fund raising supports attendance by men who were assaulted outside NSW, including outside Australia. This means that no attendees are prevented from attending because they cannot afford it.

I have provided more detailed information about the groups in **Topic E** as I consider the groups run by SAMSN are sound evidence based practice. I have also explained the complementary relationship between individual and group therapy in **A.1.2.4 Stages of recovery**.

Utilising my lengthy experience providing support services for survivors of child sexual assault, I have over the last two years provided a series of training workshops around NSW for Victims Services' counsellors. I have also conducted professional development workshops for professionals in my role as Chairperson of the SAMSN Advisory Board and further information about these including a summary of responses is included under **Topic D.4 contribution of professionals to the SAMSN model**.

I have included the preceding information to demonstrate my extensive experience working with survivors both individually and in groups. I believe that working with many hundreds of survivors, especially males, has provided me with a unique view of the issues they face both as a result of the original abuse as well as difficulties they face in recovery.

Because my experience has been working with adult survivors I will generally limit my comments to this group and allow others with the relevant experience to address the area of victims' needs.

RESPONSE TO ISSUES PAPER 10

Definitions of Advocacy, Support and Therapeutic Treatment Services

I endorse the statement from the Commission regarding "the lack of quality support services as well as a range of difficulties victims and survivors face when seeking support and therapeutic treatment services". Although my experience is limited to NSW where this statement has been true for many years, I expect it is has broad relevance. Adult survivors of complex childhood trauma, which includes children who have been sexually abused, are without doubt the largest group requiring support and therapeutic services in our community. Dr Cathy Kezelman, President, Adults Surviving Child Abuse (ASCA) in the introduction of **ASCA's Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery**, states that:

“Trauma is not simply an individual misfortune. It is a public health problem of major proportions.”

The work of the Royal Commission focuses one aspect of trauma, the sexual abuse of children within institutions. However through its work the Commission highlights the damage done to children who suffer all forms of complex trauma and struggle with the consequences as adults. Acknowledging these broader implications I will direct my comments to the “Consultation Questions” as outlined in Issues Paper 10.

Under **Defining support services** in this document, it is stated that services “need to address the impact of child sexual abuse and trauma as well as assist them to heal and lead a fulfilling and meaningful life”. I would add here the need to specifically acknowledge that healing from trauma is possible. This goes to the heart of understanding complex trauma where help is focussed on enabling people to recover from what has happened to them rather than fixing what is wrong with them. This is trauma informed practice. It acknowledges what has happened, what harm has been done and that recovery is possible.

Advocacy and Support

I endorse the comments made in this section. It is important to recognise that survivors of abuse are often isolated and that support covers a broad range of activities in a large number of settings. I would however suggest a further specific aspect of support that I consider is crucial to the ongoing recovery of survivors. That is the Commonwealth’s role in a redress scheme. There is already evidence that organisations in which children were abused may be continuing to deal with the issue as an exercise in “corporate damage control”. I suggest that it is critical that the Commonwealth acknowledge their role in oversight and involvement in the redress scheme, as already identified in documents produced by the Commission. In this way the Australian Government, representing all Australians is supporting survivors in their recovery. It places prevention of child sexual abuse and recovery for survivors within the context of shared responsibility of all the community. It also sets up the condition whereby the adversarial model need no longer be applied in the redress scheme. To date the adversarial model continues to question the experience and integrity of survivors and further isolates them.

Therapeutic treatment

I endorse the comments made in this section. I would simply add the point that therapeutic services need to be accessible in a range of services not just those specifically aimed at survivors of child sexual abuse. These would include services for people with substance abuse, mental health problems, rehabilitation services in prisons, child and family services and aged care facilities amongst others.

I will explore this in under **Topic A.2 Victim and survivor unmet needs**

CONSULTATION QUESTIONS

Topic A: Victim and survivor needs and unmet needs

A.1 Victim and survivor needs

Provision of services to any client group needs to follow four main principles. Services need to be accessible, appropriate to the needs of the consumer, provided in a timely manner and of good quality. It is within this context and an overarching guarantee of safety (physical and emotional) that services for victims and survivors need to be delivered.

A.1.1 Services that are accessible

All barriers to services should be eliminated or minimised so that victims and survivors can access services. This means consumers will not be denied access for reasons of cost, location, barriers of language or culture as well as ensuring gender equity including clients being able to exercise choice of gender of service provider. This latter point highlights the overriding requirement that consumers, who have been sexually abused, have specific needs around safety. Victims and survivors should also be able to access services that are accessible without unreasonable travel times or distances. This implies that especially in rural and isolated communities these services would be co-located with other facilities providing other services. It further implies that existing staff of such centres would need to acquire/maintain the professional skills to be able to provide the required support and therapeutic services to this group.

A.1.2 Services that are appropriate to the needs of the consumer

Because survivors of childhood sexual abuse have experienced complex trauma in their earlier years, the most appropriate models to utilize when working with this group must highlight and ensure safety and be carried out within a framework of trauma informed practice.

As already identified in previous documents from the Commission many survivors are likely to require access to different forms of support at different times during their lives. This statement is supported by the work of Mike Lew (author of "Victims No Longer" 1989 plus updates). This book specifically aims to support men recovering from child sexual abuse. He describes the stages of recovery that survivors pass through. They are: **Information Gathering, Initial Disclosure, Individual Therapy, and a Group Experience**. He makes the point that this is a guide and may not be applicable to the all survivors. I will now examine these in more detail.

A.1.2.1 Stages of recovery: Information gathering

Because there is so much secrecy, confusion and fear attached to being abused, many survivors and indeed children currently being abused find it difficult to discuss their situation with others. Children/young people need to have easy access to information about sexual abuse. The subject needs to be raised in an informative and safe way from early years in schools with a focus on victims not being blamed. Parents and others also need to have access to material that helps them understand the experience of abuse and how to support a young victim. The work of the Commission has ideally set the stage for this approach having exposed the issue via public hearings and media releases.

Survivors have different needs and will often commence their recovery journey seeking information, often anonymously. This is most likely to be online. The information should not be complicated or presented in a way that requires high levels of literacy or education. This is because many survivors have educational deficits, including reading difficulties, caused by abuse having disrupted their education. To further this information should be available via both material that can be read as well as audio files. Children/young people with disabilities are, as research has indicated, particularly vulnerable to sexual abuse, so information should also be available in forms that are accessible to people with a range of disabilities.

Although men and women face similar issues when recovering from sexual abuse, there are nevertheless significant differences. The provision of online information needs to reflect this with tailored material addressing the needs of both female and male survivors. There are already some organisations providing this sort of information including The Education Centre Against Violence in NSW and Living Well in Qld, amongst others. Some of this information is via downloads of pamphlets/booklets published through these organisations and Living Well has produced very useful apps.

Survivors also present to various organisations for a multitude of reasons. Information around abuse and recovery needs to be available at these services along with other more general health information related to their activities or specific client groups.

Suitable blogs and other forms of shared information need to be easily accessible and understandable. However rather than just leaving survivors to search through the available information online, government health and legal agencies could provide guidance towards those resources that provide correct, reliable information that is not going to exploit or misinform survivors or promote an irresponsible fringe approach.

Self-help organisations such as SAMSN have a clear role in this regard. Adult survivors often feel most safe when discussing their issues with other survivors and I will expand on this under **Topic E**. Self-help organisations are also well placed to collect and provide access to a variety of material and information useful to survivors at the information gathering stage of their recovery. Of course making contact with a self-help organisation increase the likelihood of engaging in later stages of recovery.

A.1.2.2 Stages of Recovery: Initial disclosure

Children/young people currently being abused:

Patrick O'Leary in a number of his Australian studies has stated that it should not to be assumed that disclosure is necessarily a safe thing to do. He found that in fact disclosure was for many children, detrimental to their recovery. I have heard from many survivors that when as children they disclosed abuse, they were told they were not believed or punished for speaking out and in some cases were even subsequently abused by the person to whom they disclosed.

However it must be acknowledged that early disclosure should ideally stop abuse. It should also facilitate earlier commencement of recovery with less opportunity for dysfunctional coping strategies to become entrenched. Broadly the approach should be to encourage victims who are being abused to (a) disclose early and (b) in a safe way to a safe person. However responses to disclosures must be tailored to suit the needs of the survivor, their age, and their stage of recovery.

I would like to emphasise that particular attention be paid to the needs of teenagers who are being abused. The Commission has already pointed to the age at first abuse frequently being during teenage years. In the media release in January 2014 the Commission claimed that amongst those contacting them 62% claimed to be between the ages of 10 and 18 when first abused.

Adolescence is a crucial time for personal, social and sexual development. It is also the time at which young people emotionally move away from their parents and attach to their peers. Abuse at this time can, in the words of many survivors, lead to a lonely and confusing adolescence. This is especially true for males because perpetrators are in most instances also males. In these cases there is obvious potential for the abuse to be incorrectly equated with adult gay relationships. Because of the strong need to belong to a social group many teenagers who are being abused will not want to disclose, especially to their friends as that could risk judgement, rejection or ridicule. Fortunately this group is also very connected through the internet and social media and it is in this area good quality information about abuse and services to support disclosure and recovery should be easily accessible.

When encouraging adolescents to seek help those who were abused during their younger years should also be included. My experience working with adult male survivors indicates that many did not understand at the time, that the relationship they had with the perpetrator was sexually abusive, if the abuse occurred before puberty. It is often during their adolescence, after they have sexually matured they come to understand the sexually abusive nature of the relationship. It is at that point of realization they also need support and assistance.

While educating children/young people about abuse and encouraging them to speak to someone is important, it is also crucial that the people to whom they are likely to disclose are equipped to deal appropriately with the disclosure.

Ongoing training needs to support this in schools, sporting and cultural organisations, police, health and indeed all services and organisations likely to have contact with children. Children/young people should also be included in this training, as it is well known that children being abused often feel safest disclosing to another child they know and trust. Much of this work is already being done but a renewed national programme should follow the work of the Commission to take the opportunity to “strike while the iron is hot” and the issue is in the public eye.

Adult survivors:

The Commission has already pointed out the time taken for many survivors to disclose. Experience shows that adult survivors can disclose their history of abuse at any stage of life and disclosures can be made to a broad range of people.

Family members are often the first point of disclosure but as previously stated, this does not always bring about a good outcome for victims. In my experience this statement is also valid for survivors. Family members may have an interest in maintaining secrecy around the abuse, may also have been involved, may be confused or in some cases triggered around their own earlier experiences. There are many reasons family members may not respond appropriately to a survivor disclosing abuse that happened to them earlier in their lives. To encourage a response that assists the survivor there should be good quality, easily accessible public information covering facts around sexual abuse that describes how to respond to a disclosure and support the person who has disclosed. Clearly as for victims, the earlier appropriate help is available to a survivor the greater is the likelihood of minimizing damaging outcomes.

Frequently the person to whom the disclosure is made is a professional. This could include GPs or other health providers

including a range of counsellors; police and others in the legal professions; teachers and other staff within educational institutions; and personnel working within religious institutions. This reflects the ubiquitous nature of sexual abuse and the large numbers of affected people within our community. It also reflects the need for a response to this common health/welfare/legal issue across **all** sectors. These services where disclosures may occur should have staff trained and equipped to professionally and safely deal with these disclosures. Inappropriate responses can delay a person's recovery by years and in some instances even have fatal consequences.

Self-help organisations have an important role to play. As such, these organisations have identified themselves as specifically working with and supporting the survivors of sexual abuse. Survivors often see them as a safe place as the first point of contact. These organisations often receive phone calls from survivors who identify as having been abused but also disclose that they have not discussed it with anyone before, often not even their partner or other family members. As in my comments above re information gathering, this first contact can be made anonymously via a phone call. A person from a self-help organisation is likely to be seen as a safe person with whom to discuss a difficult and private matter such as having been sexually abused.

A.1.2.3 Stages of Recovery: Some type of individual therapy can be helpful

As a clinician working in the field I recognise the need for appropriate counselling to be accessible to survivors of child sexual abuse. Of course not all survivors will feel the need to access counselling but those that do should have access to supportive counselling that addresses their needs and promotes recovery. The person providing the counselling requires expertise and training appropriate to work with the client group and utilise specific skills with trauma survivors. Although the counselling would be trauma focussed to address the abuse issues it may include other aspects depending on the need of the client. For example a person with a sexual abuse history and with a subsequent substance abuse history would need assistance with both issues. Of course this may not be from the same person or at the same time.

Often the most appropriate approach is multi-disciplinary and could include professionals from a counselling background, say psychologist or other trained counsellor, a medical professional able to provide medications when needed and people with case management skills as appropriate.

The importance of a trauma informed approach to counselling and supporting survivors of child sexual abuse.

In recent years there has been a confluence of factors that has changed the way in which we respond to childhood trauma survivors. The work of Judith Herman from the 1990s followed by the likes of John Breire and Bessel van der Kolk, has clarified the differences between post-traumatic stress disorder resulting from a traumatic incident and complex childhood trauma resulting from ongoing, often repetitive trauma that occurs within the context of a relationship. Their work has resulted in a re-focussing on the relevance of the earlier work of John Bowlby around the importance of childhood attachment in the later psychological and socio-emotional development. At the same time Siegel, Doidge and others began exploring the possibilities of neuro-plasticity, the brains ability to change itself including when a person is recovering from complex trauma. While these developments were occurring there has also been a worldwide move to breaking the secrecy surrounding childhood sexual abuse. An important example of this has been the establishment and work of the Australian Child Abuse Royal Commission. These separate but connected events have lead to a refocussing on the response to survivors of childhood trauma, including childhood sexual abuse. As so well described in ASCA's Guidelines, this new approach is the Trauma Aware and Trauma Informed approach to working with all survivors of complex trauma, including childhood sexual abuse. It acknowledges the frequency of childhood trauma, the effects it has on children and their subsequent adulthood, but also the possibility of recovery.

Along with many other professionals who work in this field I have found my work practices have changed to reflect this new environment.

Recently research has emerged that supports this new approach. An example is a recent Australian study, already quoted elsewhere by the Royal Commission. *"What aspects of counselling facilitate healing from childhood sexual assault for men and women? A phenomenological investigation"*, Vilenica et al (2014). This study describes the type of counselling abuse survivors find most beneficial. The study interviewed female and male survivors asking them what had helped them. The results strongly supported the new trauma informed approach. In summary, they found that survivors gained most from being validated and assisted to understand the dynamics of abuse including the role of grooming, and having their responses both at the time and as adults acknowledged as normal responses to severe trauma. They were assisted when counselling enabled them to understand triggers and their strong emotional reactions to them and by connecting to a positive feeling of self. The study also found the nature of the relationship with the counsellor was crucial in particular around safety and trust. Counsellor knowledge of child abuse and its effects, and an understanding of the need to provide hope around recovery were important. No particular therapeutic techniques were

found to be preferred, but rather the nature of the therapeutic relationship was found to be crucial with the counsellor neither over-emphasizing the abuse nor minimizing it. All of these results are consistent with a trauma informed approach to working with abuse survivors.

I endorse the findings of this study and consider the document a good guide to appropriate counselling strategies to successful work with survivors of childhood sexual abuse. In discussions with colleagues I have found they also support the findings and note that the study focuses on general approaches to working with survivors that rely on being client focussed, promoting safety and working in a trauma focussed way that includes knowledge around child sexual abuse.

A.1.2.4 Stages of Recovery: Some sort of group experience can be helpful.

“Even to be in a group of men, something that has always terrified me, it was amazing to feel safe and accepted and to know I am not a freak for what happened or how I feel but all the other survivors have pretty much the same experiences”.

“I feel more supported, more self aware, like I have more tools to tackle the challenges that I face as a result of being sexually abused when I was a boy. It is immensely helpful to spend time in the company of others who understand me.”

“What occurs at SAMSN (groups) is important in the broadest way. The healing that can occur can turn lives around. Recovery from sexual abuse can’t be done alone.”

Sitting in the group with twelve other survivors, it was like seeing twelve light bulbs all going on at the same time.”

The above quotes are from men who have participated in SAMSN groups for adult male survivors of child sexual assault and are typical of the overwhelmingly positive responses participants have made after completing an eight-week cycle of the groups. I do not intend at this point to discuss factors that I consider lead to the success of the groups as I will deal with that under **Topic E**. However I will in this section, outline the complementary relationship between group activities and one to one counselling.

It has been my experience over many years, facilitating many groups for male survivors, that group therapy is an ideal strategy to promote recovery for survivors of childhood sexual abuse. Being in a group with other survivors, overturns so many of the dynamics of the original abusive childhood experience. Most importantly it challenges the isolation and secrecy of the abuse, the feeling that “I was the only one” and that “there is something wrong/bad about me as a person”.

Challenging old beliefs by being in a group with other adults with similar histories promotes recovery through neuro-plastic change. With the support of others in the group, they can view the abuse from the point of view of a safe adult survivor rather than being trapped in the old feelings of an abused child. Participants talk of the power of being with other men “who get it” or “who really understand what it was like and what it does to you”. Men often talk of “the brotherhood of the group”. Safety of course is the key and crucial factor.

The SAMSN groups are not the only groups to be conducted for survivors though as far as I am aware there are no other groups for males being conducted at present in NSW. In the past successful groups held for survivors, include those following a “narrative” model and those held under the Jacaranda Project developed by the North Sydney Sexual Assault Service. The efficacy of group work is generally accepted within the sexual assault sector and there is a significant literature supporting groups being particularly helpful for adult survivors of child sexual abuse.

As stated above, group participation should be seen as complementary to one to one counselling and not as an alternative. Men who appear to gain most from the groups have had or are currently receiving one to one counselling around the issue. In the past the experience has been that men who have not already received one to one counselling can find the group experience overwhelming and tend to drop out. The risk is of course that they experience themselves as having “failed” the group, which is not a good therapeutic outcome. It should be remembered that a group dealing with and talking about trauma has an element of vicarious trauma attached, albeit in a safe setting. Members are not only encouraged to speak of their own experience but they are also exposed to the experiences and stories of the other men in the group. Much like one to one therapy, group therapy relies on participants feeling safe in order to benefit from participation. It is the SAMSN practice to point out during assessment the advantages of having already experienced one to one therapy as it prepares men for the group and maximises their chances of benefitting.

I have spoken to colleagues who have held similar groups for females and they agree with the statement that a gender specific group provides a safe space to deal with issues of sexuality, gender and relationships. It is consistent therefore that the group facilitators should be of the same gender as the participants.

Of course every person’s recovery will be different and Lew’s model of stages of recovery is a guide only. However the model is useful in that it describes not just the stages of recovery but provides the opportunity to consider the needs of survivors at those stages of their recovery.

A.1.3 Services that are provided in a Timely Manner

Broadly speaking survivors should be able to access help and support when they need it. However as I have already argued the earlier a survivor seeks help the less chance they will experience the damaging effects of dysfunctional coping strategies and the ongoing isolation inherent in “maintaining the secret”. It is important therefore to create an environment whereby survivors are more able to request help and that this occur as early in their lives as possible. This would involve both public education to encourage survivors to seek help and professional education to enable those receiving the disclosures to respond appropriately.

As SAMSN’s experience has indicated and as Lew has asserted, group activities can be helpful for adult survivors of sexual abuse. However as previously stated, my experience having facilitated many groups would indicate that there is an aspect of timeliness around group participation as best practice indicate that it should follow one to one counselling.

A1.4 Services that are of a Good Quality

As with all services in the health and human services those for victims and survivors of child sexual assault should be involved in a system of quality assurance and quality improvement. This should to be in place and as an aspect of accountability and a condition of funding. Any organisation providing services to these client groups should participate in licensing arrangements including the pre-requisite to submit their activities to examination by quality surveyors. Government and many NGO services already operate under this system.

Topic A: Victim and survivor needs and unmet needs

A.2 Victim and survivor unmet needs

Because our community has only recently begun to deal with the issue of childhood sexual abuse, there is a significant range of unmet needs for victims and survivors. In Australia the Royal Commission has highlighted this by bringing issues around childhood sexual abuse to the attention of the public.

In response to this situation the ASCA Guidelines point to the need for all organisations in the human services sector, including health, to become trauma aware and to be able to work in a trauma informed way. However there is still a long way to go and many needs of survivors are not being met.

A.2.1 Unmet needs within the health sector

A.2.2 The need for services specifically aimed at the needs of survivors of child sexual abuse.

I am aware of many concerns expressed by people working within the health sector around the system of accountability in regard to the funds provided to services at the time of the setting up of the Royal Commission. I am not indicating that I believe that there has been any misappropriation of funds but note that in spite of the significant funds being made available there has not been a corresponding increase in services for survivors. For instance in NSW I am not aware of any groups being run for male survivors apart from those run by SAMSN, who received no funding at the time of Royal Commission was set up, and only occasional groups for females mostly run by NSW Health, Sexual Assault Services, again not funded by the Commonwealth. Because a significant percentage of funding went to organisations without a history of provision of services to survivors of sexual abuse, there has been an increase in professional training however there continues to be a significant delay in the required counselling services to be up and running.

In some states there has been a welcome increase in access to counselling through various services for victims of crime. In NSW this has occurred with survivors able to access counselling at no cost through Victim Services. They fund access by survivors to registered, approved private practitioners. This is a successful programme financed by the NSW Department of Attorney General and Justice, again a NSW Government funded programme with, as far as I am aware, no Commonwealth Royal Commission funding. However there is an inherent limitation in this system as there is no access agreement between states. As a result people who reside outside the state in which they were abused have great difficulty, or find it impossible, to access counselling as state programmes aim to support victims of crime where the offence occurred within that state. An agreement between all Australian States and Territories to enable victims of crime to access counselling, irrespective of the state they currently live in, would resolve this. Another issue around accessibility that would however continue to exist is the unaddressed needs of those many Australians who were abused outside Australia but have subsequently migrated here. This number is significant and in a country priding itself on its multiculturalism, this remains a serious unmet need.

As a result of these various limitations, many survivors are unfortunately limited to accessing professional counselling through the GP Mental Health Programme. This allows a maximum number of ten sessions per year. For most survivors of child sexual abuse this is completely inadequate. Indeed many psychologists are reluctant to take on such clients under this programme, as it is often not in the client's best interest to begin to deal with the complex issues of abuse, only to run out of sessions in the early stages of therapy. The cost of ongoing treatment can in such cases lead to an unreasonable burden of debt as survivors finance their own counselling.

Many survivors attempt to access counselling services via the public mental health sector. Under current arrangements this is not appropriate for many abuse survivors as these services are generally designed to provide crisis services and maintenance for people with mental illnesses. Some survivors may benefit from this approach if they have a psychiatric disorder or experience symptoms of a psychiatric disorders that has emerged as a result of the abuse. An example of this would be a survivor who at times becomes depressed. However their long term need is access to ongoing supportive counselling to promote recovery from the trauma they have suffered. Under current public mental health practice and staffing levels, where work is focussed more on brief interventions, it can be seen that trauma focussed work is in many ways, not compatible with current practices.

An alternative source of counselling for adult survivors of child sexual abuse could be seen as being appropriately provided within the public sector through sexual assault services. Certainly the professional skills and expertise of the staff of these services would be appropriate to the needs of survivors of historic sexual abuse. As stated earlier my experience relates mostly to NSW, and I have found that services for survivors, particularly males, is extremely limited within sexual assault services.

Through their advocacy work for men who were sexually abused when they were children SAMSN staff often inquire about access to counselling services on behalf of men who have made contact. An outline of the responses that they have noted when attempting to access counselling through sexual assault services for adult male survivors are detailed in **Addendum 2** to this submission. However, in summary they found that:

- As far as they were able to determine there are no male counsellors currently employed in NSW sexual assault services, so that in spite of NSW Health policy stating that clients should be able to have a choice as to the gender of counsellor, this is not possible for anyone who would prefer to speak with a male
- Because of staffing levels in sexual assault services and the resultant need to prioritise services to those who have experienced a recent sexual assault, counselling for any survivors of child sexual assault will involve a lengthy waiting time (up to a year) or simply not be provided.
- Initial responses to requests for access to counselling for childhood sexual abuse is sometimes very discouraging for survivors
- There are very few group programmes for female adult survivors of child sexual assault and none for males

For services generally, including NSW Health sexual assault services they found that:

- In spite of significant Commonwealth funding as part of the implementation of the Royal Commission there is still lack of services for survivors of child sexual abuse, in particular for male survivors.
- The above situations are not improving

The overall picture is that there is a serious shortage of specific services for survivors of child sexual assault that do not put a significant financial burden on the survivor. This is a significant issue around equity of access to health

services for this large group in our community. We know what will help many of them recover but this help is often not available.

The families of survivors also have specific needs around supporting those affected by abuse and their needs should be recognised as part of survivor services.

A.2.3 Need for the broad range of health and other services to address the needs of survivors of childhood sexual abuse

Many health services where survivors seek support aim to deal with the dysfunctional strategies they use to cope with the troubling memories of the abuse. That is they seek and receive treatment for the symptoms of the abuse rather than for the experience of the abuse itself. These “symptoms” include substance abuse, various mental health problems in particular mood disorders and eating disorders, dependent gambling, self harm, compulsive sexual activities, low self esteem and of course relationship problems. That is not to say that every person who suffers from any of the above has a history of child sexual abuse, however survivors of childhood abuse, including sexual abuse, are frequently represented amongst consumers receiving care in these areas.

I have mentioned the difficulties survivors face in the mental health system where the service model does not meet the needs of survivors. I would like to note similar issues in another key area, services for people who have a history of substance abuse or compulsive gambling.

One of the difficulties many survivors experience as a result of childhood trauma is emotional self-regulation. They can become overwhelmed with feelings of fear, anxiety, anger and sadness related to grief and loss. Perhaps the most disturbing are the feelings of self-hatred many survivors experience. In the context of childhood sexual abuse, these are “normal” outcomes for many survivors. In an attempt to contain these feelings some use strategies that can result in serious self-harm. Perhaps the most common is self-medication involving the use of drugs, including alcohol. Unfortunately this coping strategy leads to further complications, as over time they feel the need to increase dose levels which in turn risks physical harm and physical and/or emotional dependency.

Childhood sexual abuse is now being recognised as a common factor behind a significant number of people who abuse substances. Many years ago I spoke to a male abuse survivor who told me that: “I have been through so many detoxes and rehabs. They talk about the ‘revolving door syndrome’. Now that I am dealing with being abused when I was a kid, I know what it was that kept that door going around.” I have heard his thoughts repeated many times. Every group I have run for male survivors has included men who have had or continue to have substance abuse problems. Because many survivors wait for years before disclosing the abuse, in the intervening time they misuse various substances with potential to cause them physical, emotional, relationship and financial harm.

When the groups for male survivors started in the early 90's it was unusual to hear that participants had gambling problems. However over subsequent years it has evolved that every group will include men who have experienced problems with compulsive gambling. Much like drug use, survivors use gambling to temporarily calm themselves, in this case diverting their attention from their internal struggles and emotional distress. A client once told me that when he was in a TAB he experienced "an overwhelming feeling of peace". When I asked him what he meant he told me "when I am in there focussing on the screens, and on my bets – that's the one time I don't think about the abuse." More recently the use of gambling as an avoidance strategy seems to be focussing on the use of poker machines. Recent media reports have highlighted how poker machines are designed to capture and hold the attention of gamblers and entice them to continue to use them. That is exactly what I have heard happens to many survivors using these machines. Unfortunately as governments have become more dependent on revenue from gambling, access to poker machines has become easier. This has led to an apparent corresponding increase in survivors using that form of gambling as a coping strategy. This is an area urgently requiring research to confirm this apparent link.

In my experience there is a need to increase awareness of the incidence and effects of childhood sexual abuse within organisations providing supports for people with problems around substance abuse and compulsive gambling. Early intervention models with abuse survivors would lessen harm caused by these ongoing behaviours. In addition it would increase the likelihood of earlier disclosures and encourage engagement with activities to address the underlying issue of childhood trauma.

Because the numbers of sexual abuse trauma survivors are so great we must assume that they will present to the whole range of health services with a whole range of issues. When they do it must be recognized that they also present with a crucial need, to be reassured of their safety in ways that other members of the community may not require. This goes to the heart of difficulties survivors can experience around trust, fear of people in authority, feelings of powerlessness and of course physical touch. Physical examinations are of course a prime example where survivors of child sexual assault may find the prospect so threatening that they may postpone treatment or avoid the situation entirely. The outcome can be that they are unable to access services available to the rest of the community.

Perhaps this is best demonstrated by examples, both with good outcomes.

- Recently a colleague told me of a young woman who needed a Pap smear. She claimed that she was only able to undergo the examination because the women's health nurse was aware and sensitive to her history of abuse and took the whole examination slowly, explaining everything as the procedure progressed. She frequently checked in that the young woman was comfortable to continue and that she understood what was happening and why.

- A male client of mine who had a history of abuse needed a physical examination for a long-standing bowel problem. With his permission I was able to explore with a hospital clinic what could be done to help him deal with his fear of the examination. The clinic staff were keen to help and to reassure him. They were able to offer the use of a tranquiliser during the examination that avoided him being traumatised. As a result he received appropriate care that he had not been able to access for years.

There are particular issues for women around birthing. Some maternity units now routinely inquire of women if there are any issues around any physical or sexual abuse that could create concerns for them around giving birth. Of most concern is that the woman can be triggered during the birth and be overwhelmed during that already difficult time, by memories of a previous sexual abuse. This is a difficult discussion but can, with care and respect, provide reassurance for female survivors at the time of the birth as well as during pre and post-natal periods.

These examples provide clear evidence that, as ASCA claims in their Guidelines, ALL services need to be aware of the inevitable fact that survivors of child sexual abuse will from time to time present. Accepting this and having staff trained to be able to reassure and support these consumers, means services work in a trauma aware and trauma informed manner that enables survivors to overcome barriers to accessing services.

Outside the area of health, survivors of childhood sexual abuse can have a range of unmet needs across multiple areas of their lives. For instance survivors are over-represented in the prison system where access to counselling is extremely limited. Again it is not unusual for men attending SAMSN groups to acknowledge criminal acts in their past that have led to periods of incarceration. Most claim that while in prison they received little help around their history of abuse. It is perhaps ironic that there are programmes within corrections for perpetrators of sexual abuse but little assistance for their victims. Again this is an area needing further attention including research around the numbers of survivors in prison, approaches that could support them and whether such help affects rates of recidivism.

Child sexual abuse can disrupt the education of victims and as a result there are many survivors with educational deficits and learning difficulties. This leads to difficulties in finding employment, ongoing financial stress and frustration around under achieving. Remedial reading and other programmes provided through educational and other institutions could address the barriers many survivors continue to experience as a result of the disruption in their schooling.

Housing difficulties and homelessness is another area of need for some survivors. The Michael Project "Increasing our understanding of homeless men" Mission Australia (2010), found that 95% of homeless men had experienced trauma with 32% experiencing "sexual molestation" or rape. This

study clearly indicates that accommodation services need to be aware of and be able to support survivors requesting their help.

There is also the complex issue of difficulties faced by people with disabilities. It is well documented that this group are particularly vulnerable to child abuse, including sexual abuse. All services for people with disabilities should be aware of this fact and have supports specifically tailored to abuse survivors involved in their programmes.

The Royal Commission has on many occasions pointed out that large numbers of survivors of child sexual abuse do not disclose for years, sometimes decades after the abuse has occurred. Indeed many of the survivors coming forward to the commission were abused years ago in institutions that no longer exist. Support for survivors is therefore an issue that can even emerge in the context of aged care. There are stories of elderly people who have a strong desire to tell what happened to them as they “do not want to take the secret to their graves”. Frequent media coverage of the issue increases the likelihood that the elderly will have memories of abuse triggered distressing them and making them more likely to talk about the abuse they experienced. On occasion residents of aged care facilities who are experiencing deteriorating cognitive function may also become less inhibited and disclose abuse that happened to them many years ago. In such cases staff need to be trained in how to respond appropriately to these distressed elderly survivors disclosing childhood abuse and services need to be able to support staff to whom disclosures are made.

Clearly there is a great need for professional training around the needs of abuse survivors in a broad range of generalist and specialist services. This should go hand in hand with funding specialist trauma services that could advocate on behalf of survivors when they present to these other health and human service agencies.

Seeing the effects of childhood abuse “everywhere” is not just a biased view of someone who works in the field. It is simply facing, as the ASCA guidelines point out, the ubiquitous nature of childhood abuse and its potential to continue to cause survivors problems into adulthood. Addressing these issues involves a lot of public education, acknowledging the numbers of survivors that seek services within the human services field. It also involves prioritising trauma awareness training for professional groups both in their basic training and their ongoing professional development. Enabling staff to discuss the complex and confronting issues around child sexual abuse both increases the professional capacities of the staff and maximises opportunities for survivors to deal with their issues.

Topic B: Diverse victims and survivors

B.1 Males

Sexual abuse can happen to anyone, from any background; rich, poor, from any culture or background and of course of either gender. However it is comparatively recent that males have been recognised as potential victims of child sexual abuse. Because of the Royal Commission's focus on people who were abused in institutions, there have been a large number of men who have subsequently been identified as survivors of sexual abuse. Dissemination of this information via the media has clearly demonstrated to the community that boys are subject to abuse as well as girls. This is in sharp contrast to when I started working with survivors of sexual abuse. Views were frequently expressed similar to "It doesn't happen to boys, does it?" As stated earlier in my submission although attitudes may have changed, there is an ongoing lack of services available to men. The abuse of girls and young women emerged during the 80s as a result of attention being paid to mistreatment of women. Acknowledgement of boys being abused is part of ongoing recognition of the vulnerability of all children to sexual abuse. It is timely therefore that evidence emerging from the Royal Commission results in overdue action around the provision of services to meet the needs of male survivors that I have discussed in more detail in the previous section on unmet needs.

B.2 Members of the indigenous community

There is a great need for programmes addressing both the prevention of child abuse and support for survivors within indigenous communities. For a number of reasons this is a difficult need to address. Apart from abuse within institutions indigenous people can experience abuse by perpetrators from both outside and within their communities. To compound the issue further, many indigenous people live in rural or isolated communities where support to disclose, to confront current abuse and establish privacy and confidentiality around support, create additional barriers. These difficulties face both adult survivors and vulnerable children/young people and includes both males and females.

I have found that some indigenous people prefer to discuss abuse with someone outside their community. They claim that for reasons of privacy and to lessen what they see as a risk of being judged by other members of their community, they feel safer disclosing and receiving counselling from "an outsider". Seeking help from a professional outside their community can also overcome barriers to disclosure and treatment caused in certain situations by complicated extended family structures. These complications can occur if the victim/survivor from one family group makes claims against a person from another family group or a person with status within the community. Another barrier to disclosure within the indigenous community is the fear that disclosing sexual abuse will bring shame upon their community and risk reinforcing racial prejudice within the white community.

The possibility that non-indigenous workers can support indigenous survivors does not of course mean that there is not an important role for indigenous workers to provide services to survivors within their own or other indigenous communities. This highlights the serious shortage of indigenous health workers with adequate training and skills to address issue of abuse within the their communities.

There is an opportunity for members of the larger Australian community to consult with and support indigenous people and, as we do with other people who are survivors of child sexual abuse, point out that recovery is best done with support. This should be approached through sensitive consultation with members of the indigenous communities. The aim would be to determine the best way to provide support to those individuals affected and to help the indigenous community as a whole create safer environments for children/young people.

B.3 People of varied sexual orientation and identity

Because of the very nature of childhood sexual abuse, those working in the field will frequently work with people with varied sexual orientations, including those who are confused and unsure about whether they are gay or straight. It is certainly a common experience for males, especially heterosexual males to feel confused around their sexual orientation, in particular when the person who assaulted them was another male. Workers need to be open to dealing with these issues as survivors strive to gain clarity around how the abuse has affected their sexual orientation and their view of themselves.

People with varying sexual identities will also present with issues around abuse. Services and the workers who are employed should be familiar with issues facing survivors in this diverse community and be able to provide an accepting and safe environment for them to discuss their issues and not allow this to become a barrier to their recovery. Organisations such as ACON are familiar with these issues and actively support and advocate on behalf of their clients.

Topic C: Geographic considerations

C.1 People living in rural and remote areas

Australia is a highly urbanised country and it has long been acknowledged that people living in rural and remote communities have difficulties accessing the same range of health and support services as those living in large urban areas. Survivors of abuse face these same difficulties but with additional barriers relating to the secrecy and feelings of shame and embarrassment survivors attach to their experience of being abused. In rural and remote areas fears of being exposed are exacerbated by limitations around privacy and confidentiality. These concerns are not as significant an issue for those living in the anonymity of denser urban centres. As a result survivors in rural and remote areas continue to feel isolated and find it more difficult to disclose having been abused and to seek help.

Counsellors with specialist skills in working with survivors of child sexual abuse, whose presence is well advertised but who work in more generalist services, could provide counselling and other supports while maintaining the privacy of clients. Although not as reassuring as face to face contact, other services could be provided by phone or online.

While access to one to one counselling is a challenge, I am doubtful that groups would be successful outside larger urban areas. Again this is because of fears of breached privacy and the shame and guilt survivors feel about themselves. For many male survivors one of the greater barrier is caused by the misconception that boys who were abused will inevitably grow up to be perpetrators. Unfortunately this is still a widely held belief, both within the community in general as well as by some survivors. Understandably a male survivor who still holds this belief is going to do all he can to avoid being identified as a survivor, as in his mind he would be seen as an abuser or potential abuser. This is the greatest fear for many men who were abused and is a significant reason behind them not disclosing or seeking help. As a result it is my opinion that it is unlikely that groups would be successful in smaller communities where perceived risks associated with exposure would outweigh the desire to seek support from other survivors in a group.

Because of this limitation it is even more crucial that easy access to one to one counselling is available to those survivors living in rural and remote settings.

Survivors gain an enormous amount of support by talking to other survivors. Even phone contact with another survivor can begin to overcome the isolation felt by many survivors, particularly those in early recovery. Most people living outside metropolitan areas now have access to reliable internet so that information and support provided over the internet is also a real option.

There is a need for remotely accessible service for survivors who live in rural and remote communities. Ideally the service would be available both during and after work hours. It would need to be well publicised in local media, especially at the time it was set up. Options would include separate male and female services or one service having both male and female staff including survivors available at all times. The survivors acting as support staff would need skills including some basic training in counselling and case management. The service would need to be adequately staffed with a roster to help avoid burnout and vicarious traumatisation. Best practice would indicate that professionally trained counsellors would also be present to consult with the phone counsellors, deal with crisis contacts and assist with referrals. Professional counsellors would also have a crucial role to support the survivors employed as phone counsellors. Such a service once set up could explore further outreach opportunities.

SAMSN already fulfils this function for male survivors to a degree though it is extremely limited in what it can provide because of lack of funding and the resultant shortage of personnel. However the contacts they have already

made with male survivors and their families outside urban areas is both significant and impressive given their limited resources.

Topic D: Service system issues

The terminology used in this paper to describe advocacy and support is I consider appropriate. It acknowledges both the needs of victims and survivors and the range of supports they require. Although the terms used are subsequently clarified, the examples nevertheless focus on health and welfare areas. Other areas require recognition. An obvious sector where victims require significant support and advocacy is in the legal system. Victims and survivors who are involved in legal processes frequently report that the legal system makes them feel further victimised. The need for reform within the legal system in its dealings with sexual abuse survivors is long overdue. The reforms would include staff in specific support roles assisting survivors as they proceed through the system. However at a more fundamental level the sector requires basic attitudinal change to focus on the needs of survivors, acknowledge the damaging effects of child abuse, accept the reality of ongoing effects of abuse on survivors and safeguard the human rights of survivors. These reforms should include specific court processes that support these concepts when dealing with allegations of child sexual abuse.

The definition of therapeutic treatment focuses on services specifically set up to support victims and survivors. Whilst this is of course true and a huge area of need, I have already made the point that the whole range of health and human services will deal with people who have been sexually abused. Thus therapeutic treatment does not just apply to those services designed for victims and survivors but includes the broad range of other services that need to be aware of and be able to deal with this group of clients.

D.1 Broad Reform across the health and human services sectors

As I have stated previously, responses to survivors of child sexual abuse should not be viewed in isolation but in the broader context of complex trauma. As ASCA has stated, the ubiquitous nature of complex trauma, including child sexual abuse, requires all services to become trauma aware and trauma informed. This will involve “reconceptualization of traditional approaches to health and human service delivery whereby all aspects of service are organized around the prevalence of trauma throughout our society” (ASCA Guidelines 2012).

I have already covered the need for this approach under the section **A.1.2.3: The importance of a trauma informed approach to counselling and supporting survivors of child sexual abuse**

D.2 Specific services for survivors of child sexual abuse

The service model for supporting survivors of child sexual abuse must be firmly based on trauma awareness with all activities focussed on providing a safe environment that promotes recovery. I have already outlined the practicalities of this in previous sections of this paper. Crucial strategies mentioned include appropriately trained and experienced staffing, establishing a culture of respect and acknowledging the possibility of recovery, methods to address barriers and overall an atmosphere of safety around services and the way they operate.

In planning how to respond to the needs of survivors, political commitment and high level planning should confront decisions around the need for services to become more accessible, to improve and become part of the mainstream. This process should address and define the responsibility of the public sector, how this would be translated into service provision and the role of the non-government sector and how should this be funded and monitored.

In spite of the cost effectiveness of assisting survivors to recover, realistically it is unlikely that funding in the public sector will be sufficient to be totally responsible for services in this area. However the public sector does need to be part of the solution and as such be responsible for setting benchmarks for other private and NGO sectors.

My experience working with SAMSN has enabled me to view first hand a model that an NGO service can follow that meets many of the needs of adult survivors. This model involves survivors and professionals working together within a single organisation to provide a range of services. SAMSN has, with little funding, few resources and very limited staff developed this model that I believe shows enormous potential.

I will now highlight some of the strengths I have seen of this model. To summarise the approach I shall call it **The SAMSN Model**.

D.3 Contribution by survivors to The SAMSN Model

Having made contact with staff from SAMSN who are survivors, many men have made comments like “You are a survivor so you know what I am talking about – you get it” or “It feels so good to talk to another survivor, it helps me to know that I am not alone”. There is a unique role that one survivor can make to the recovery of another survivor. Contact with a worker who is a survivor can be particularly powerful as it challenges the isolation, confusion, embarrassment and the feeling of being different that can persist from the original abuse. It is common for those who have used SAMSN services to talk about the “brotherhood” they have joined which for many replaces family that has let them down or even been part of their abuse. It is also worth noting that many family members who are affected by a loved one’s abuse, also call SAMSN and claim that they feel supported and understood by a recovering survivor.

A lot of men have claimed that they feel that their struggle is acknowledged simply by knowing that SAMSN exists. It helps them feel empowered by knowing the staff member they are speaking to is also a survivor continuing to make progress in their own recovery. This highlights the important opportunity for modelling as those who have already made significant recovery can model this progress to other survivors.

SAMSN's advocacy role is particularly important as survivors frequently gain great strength knowing that when dealing with a situation that they find confronting, again knowing the person supporting them and advocating on their behalf is another survivor. Survivors frequently know best what survivors need and how these needs can be met. This model also has the additional benefit as survivors performing the advocacy role also gain strength from their involvement. SAMSN has discovered that contributing to the activities of the organisation promotes the recovery of all those involved. As stated previously these supporting survivors would require training in basic counselling skills as well as case management. This will enable the support they offer to be more effective and enable the staff member to flourish in the job, gain more skills and of course promote their own recovery.

D.4 Contribution of professionals to The SAMSN model

Since SAMSN was founded, it has benefitted from the involvement of professionals within the organisation. This involvement has included membership of the Advisory Board, facilitation of groups and more generally the support of survivors and the organisation.

The Advisory Board provides support and advice to the SAMSN Board and is made up of professionals with a mix of clinical and academic experience as well as training in the area of child sexual abuse. The Advisory Board also includes a community representative, a man who is a survivor and who has completed a SAMSN group. The board meets regularly and reports to the SAMSN directors on a broad range of topics. I am the current Chairperson of the Advisory Board.

The main contribution of professionals is organising and conducting the eight-week SAMSN survivor groups. Apart from facilitating the groups, they have developed the psycho-educational reading materials used in the groups, they assess those applying to join the groups and support group participants experiencing difficulties, discussing further referrals with them when required.

Over the last twelve months SAMSN has been conducting ongoing professional development groups with a range of professionals within the counselling community. These are aimed at furthering knowledge around issues confronting men who are survivors of sexual abuse. These workshops were both developed and presented by myself as part of my role as the Chairperson of the SAMSN Advisory Board. The workshops have been very well received and recognised as an important contribution to the ongoing professional development of participants. A summary of the groups held and feedback from participants is included in **Addendum 3**.

There are of course inherent risks for trauma survivors in their work within a self help organisation. There is a history of people who, with the best of intentions have set up self-help organisations in various fields, only to over-commit and burn themselves out. These risks are obviously exacerbated within an organisation run by trauma survivors, for trauma survivors. Apart from the clear risk of burnout there is also the serious risk of disabling vicarious traumatisation. All workers in the trauma field must manage this risk however it is a greater issue for survivors because their own experience of abuse can be triggered. The role of professionals in SAMSN has over the years evolved to include support and guidance to promote the safety and success of the men who both set up SAMSN and others involved in the organization's work. This has included discussions around dealing with stress, a professional understanding of the nature and repercussions of trauma, application of healthy and safe boundaries, identifying areas where training is needed and contributions to ongoing planning to safeguard and ensure SAMSN's future.

It is through my work as a psychologist supporting SAMSN that I have grown to have a clear understanding both of the role of survivors in promoting recovery for other men who have been abused as well as the role a professional can contribute in a structure that gains its strength on the unique support survivors can provide for each other. Adequate funding would guarantee the ongoing role of both survivors and professionals within the organisation. This would include fulltime employees and ensure the mix of professional and survivor skills and experiences that would together enable further development of a quality service to survivors.

Topic E: Evidence and promising practices

The importance of using a trauma focussed approach as a promising practice in one to one counselling has already been covered in **Topic A .1.2.3 The importance of a trauma informed approach to counselling and supporting survivors of child sexual abuse.**

Under **Topic E** I intend to confine my comments to the important and ground breaking role of the SAMSN groups.

E.1 The SAMSN Professionally Facilitated Peer Support Model for groups for adult male survivors of child sexual abuse

The groups for male survivors conducted by SAMSN are consistent with and support a trauma aware model of practice, in much the same way as counselling practice mentioned previously.

The SAMSN groups for men who were sexually abused as children are based on the model Tony Phiskie and I developed at Newtown Community Health Centre in 1990. This is a **professionally facilitated peer support model.**

Before joining the group, participants undergo a thorough phone assessment to determine their suitability and readiness to attend a group. The groups include men 18 years or over, of any cultural background, sexual orientation, and to a degree, a physical and intellectual disability. Men with longstanding mental health problems but who are currently stable, men with mild intellectual disability or communication difficulties and those with a previous history of substance abuse have all participated successfully.

The group programme consists of eight sessions with meetings held weekly from 6 to 8 in the evening. Locations are chosen that are safe, provide a level of privacy and are accessible by public transport. Each weekly session has a topic aimed at helping men progress through a “journey” of recovery. The process involves stimulating discussions around topics chosen to assist participants to increase their understanding of what happened to them, how it has affected them and steps they can take to promote their recovery. The first four weeks address childhood and the participants’ experience of abuse. The latter four sessions examine how the abuse has affected their thinking about themselves, their ability to cope emotionally, and the effects on various relationships. The programme concludes by encouraging the men to look at how far they have travelled and where their recovery journey will take them next.

Participants are provided with readings at the conclusion of each weekly session to help them focus on the topic for the following week. Prior to the last twelve months these readings were chapters and articles copied from various sources. However the readings now being used were written specifically for SAMSN and designed to fit in with the weekly topics of the SAMSN groups. This development has resulted in a noticeable increase in the participants’ perceived relevance of the readings. They often bring them to the group with comments and sections highlighted and refer to them in the group discussions. Recently this material has been recorded so that men with reading difficulties can access the material via an audio file.

Two professionals facilitate each group. They have appropriate training within the field of abuse trauma and experience working both with men. The presence of two facilitators enables distressed members to be settled without the group being interrupted. It also provides a safeguard for the facilitators’ wellbeing as debriefing sessions are held after each session, which of course helps to manage vicarious trauma.

Unfortunately because of funding limitations detailed research on the effectiveness of the groups has not been possible. However at the end of all groups, participants complete a satisfaction questionnaire. Below is a summary of responses to questionnaires completed at the conclusion of recent groups. Apart from these questionnaire responses there is consistent feedback from participants that the groups have been an important aspect of their recovery with many saying the groups have been life-changing, the most important part of their recovery and had made them feel “normal” for the first time in their lives. It is acknowledged that there is a need to for further careful analysis of these questionnaire results and to conduct further research on the

effectiveness of the groups. This would ideally involve a “before and after” study. So far results from questionnaires indicate that participants found:

- The groups helped them deal with and lessen feelings of guilt, shame and anger
- They experienced an improvement in their self esteem
- Feelings of anxiety and depression lessened
- Those who had experienced previous problems around substance abuse, problematic gambling, self harm and suicidal thoughts, felt these issues were less of a problem after completing the group
- Partner and some other family relationships improved
- Issues around trust and feelings of vulnerability were addressed
- They generally felt safe, reached a better understanding of abuse and how it affected them
- They strongly valued being with a group of male CSA survivors, to share stories and experiences knowing “I was not the only one”
- The readings were highly valued (this response has significantly improved since readings specific to the groups were developed)
- The facilitators were experienced as professional, safe and “understood me”

The groups attracted a broad age range with most in the aged 26 to 60 years. Men identifying with different sexual orientations are included in most groups and overwhelmingly feel safe and accepted.

Another measure of success is the retention rate for participants for the eight-week groups. That is the number of participants who start and complete the programme. Since September 2014 SAMSN has held a total of eight groups in Parramatta, Erskineville, Granville, Wollongong, Newcastle and Adelaide. For those eight groups the average retention rate (those that completed the full cycle of the group) is 88%, which is an unusually high retention rate for any group, in particular in a group dealing with such a difficult topic. The results are summarised in **Addendum 1 Table 2**. This is a significant indicator of the safety within the groups and their overall success. The high retention rate indicates that

- The way in which the groups are facilitated encourages recovery,
- Survivors find the groups safe
- That the peer support model is sound and appropriate and that psycho-educational reading material is useful
- The phone assessment interviews aimed are successfully selecting men who are both appropriate to join the group and at the right time in their recovery.

I commend the SAMSN service model and the Professionally Facilitated Peer Support Model used in SAMSN groups as evidence based and promising practices in the area of work with survivors of childhood sexual abuse.

Finally I would like to thank the Royal Commission for the opportunity to contribute to this Issues Paper. I would also like to thank the Commissioners and other staff at the Royal Commission for their extraordinary work and efforts exposing child sexual abuse and as a result helping survivors realise that their pain is acknowledged, they are not alone and that their recovery is both possible and supported.

Addendum 1

Table 1

**Summary of Attendance at Professionally Facilitated Peer Support Male Survivors Groups to November 2015.
Combined Statistics of Newtown CHC, RPA Hospital and SAMSN.**

	NCHC/RPAH	SAMSN	Total
Number of group cycles completed.	44	16	60
Number of men who have completed one or more cycles of the group.	252	143	395
Total number of completions (includes all group cycles for men who attended more than one group)	355	147	502
Number currently on waiting list.	0	37	37
Number who dropped out during group.	62	23	79
Number for whom contact was lost while on waiting list.	148	33	181
Total referrals.	462	236	692

Note:

Groups that were started at Newtown Community Health Centre and continued at Royal Prince Alfred Hospital were run from 1992 to 2008. These groups were 1 ½ hour sessions run over 12 weeks.

Groups run for SAMSN were run from 2010 to present (November 2015).

These groups were 2 hours sessions and run over eight weeks.

Table 2

Recent retention rates in the eight most recent SAMSN Professionally Facilitated Peer Support Groups held between September 2014 and November 2015.

Location	Date	Numbers of Attendees
Parramatta	Sept to Nov 2014	Start 10/Finish 8
Erskineville	Sept to Nov 2014	Start 11/Finish 10
Erskineville	March to April 2015	Start 11/Finish 10
Newcastle	June to July 2015	Start 10/Finish 9
Wollongong	Aug to Sept 2015	Start 5/Finish 4
Granville	Oct to Nov 2015	Start 10 /Finish 8
Erskineville	Oct to Nov 2015	Start 12/Finish 11
Adelaide	Oct to Nov 2015	Start 13/ Finish 12

Overall retention rate for eight weeks: 88%

Addendum 2

Summarised results of SAMSN surveys and requests for services for male survivors. All figures result from telephone contacts made with services.

January 2013. Calls to services listed on the Royal Commission website requesting counselling or group for male survivors.

- 13 services contacted
- 8 services provided ASCA's details suggesting they would be able to provide a counsellor's name
- 2 services were able to offer counselling
- 2 services wanted the survivors to leave their name and contact details so they could be called back. Survivor not willing to disclose this information to an answering service
- 1 service (in Queensland) offered a service for male survivors of sexual violence

July 2014

- 27 services contacted all having received first round funding in July 2013
- 1 service (in Queensland) offered both counselling and groups for male survivors.
- Nationally no other service (apart from SAMSN) offered groups for male survivors.
- Many services although provided "general" counselling (some only by phone) and either did not have any male counsellors or did not offer services to males.
- A number of funded agencies referred the caller to (unfunded) SAMSN as they did not provide the service requested.
- A number of agencies provided services to children or women only and some to specific community groups or locations.
- Not all services offered were free.
- Second round funding was for organisations providing services to specific groups within the community. None provided groups for men.

October 2015

- Contact with 7 NSW Health Sexual Assault Services
- None had a male counsellor
- None offered groups for males. All had a waiting list for counselling for survivors of child sexual abuse, especially males with waiting times varying from two to twelve months. One service told the inquirer that counselling was "usually a lower priority if assault was in childhood".

November 2015

- Request for service from a metropolitan NSW Sexual Assault Service.
- Referred to Victims services for access to counselling, rape crisis for crisis counselling and ASCA for referral to a counsellor.
- Referred to SAMSN for groups or a male counsellor.

Addendum 3

Professional development groups held by SAMSN for counsellors working in the sector

Workshops held in 2015.

- Newcastle (2 workshops)
- Adelaide
- Wollongong
- Parramatta (2 workshops)

Attendees

- Total of 208 health professionals have attended the 6 workshops
- 44% psychologists, 21% social workers, 35% counsellors and “others”

Responses to feedback questionnaire completed at conclusion of workshops (response rate 88%)

Using a 5 point scale ranging from 1= “Strongly disagree” 3= Neutral to 5= “Strongly agree”.

Mean responses:

- Workshop lived up to expectations: 4.88
- Pace of workshop was appropriate: 4.85
- The presenter was well prepared: 4.95
- The workshop added to my knowledge: 4.73