Issues Paper 10

Advocacy and Support and Therapeutic Treatment Services

Submission to:

Royal Commission into Institutional Responses to Child Sexual Abuse

Date:

30 November 2015

About this Submission

ISA Inc. welcomes the opportunity to respond to the Royal Commission's consultation on Issues Paper 10 regarding Advocacy and Support and Therapeutic Treatment Services.

In particular, ISA hopes its experience in supporting people who have suffered child sexual abuse will be of value to the Royal Commission, especially as ISA has provided therapeutic treatment services and advocacy and support in this specialised area for the last 35 years in Western Australia. Therefore, ISA is well placed to provide commentary and feedback along with some of ISA's clients that have taken the opportunity to generously give of their time to respond to some of the survey. Their invaluable feedback is included in our response. ISA Board members and staff have also been consulted and have provided feedback.

About ISA

ISA was the first Non-Government Association in Western Australia to deal specifically with child sexual abuse and associated complex trauma impacts that were present and potentially can remain for a lifetime. ISA remains one of very few organisations in WA specialising specifically in this area.

ISA provides long term counselling for children, young people and adults who have experienced sexual abuse and seeks to leverage its specialised expertise by partnering with other organisations to improve recognition and responses to child sexual abuse.

ISA's youngest client that has presented for counselling was 5 years of age and ISA's oldest client was 91 years old which in some respects is indicative of no one is too young or too old to receive support. However, this is also indicative of tragically how early in life therapeutic treatment has to begin and how long and lasting can be the devastating effects of child sexual abuse that even at the end of life memories still haunt, trauma effects can still be triggered, and the road to recovery remains a life long journey.

The counselling, advocacy and support provided by ISA is not time limited in recognition that recovery from experiences of child sexual abuse can take a significant amount of time. It is also recognised that clients will at times need or want to take a break from treatment and then re-engage and return for further treatment and support when they are ready. We also know that clients may have 'relapses' so to speak in their recovery journey due to a range of factors and life events that may 'trigger' the impacts of their initial trauma experiences and the previous symptomology. It has not been uncommon for ISA to support clients on and off for a period over 5 to 10 years and recently a client contacted ISA following a 20-year break.

What sets ISA apart from many mainstream organisations, particularly those using a medical model, is that we can be responsive to client needs as mentioned previously by not being time-limited in terms of the number of sessions provided or in terms of the period of time a client is accessing the service. This approach also acknowledges that it can take longer to build a trusting therapeutic alliance when a client has experienced trauma through the violation of trust and societal boundaries being disregarded for the purpose of exploiting a child. ISA's therapeutic treatment approaches are flexible and draw on a range of modalities to facilitate appropriate responses to the individual needs of each client and to build some psychological resilience and develop a resource and support base for the clients before embarking on complex trauma and processing work. ISA draws on a phased and tiered treatment approach to establish safety and stability first.

ISA's History

In 1978, Women´s Health Care House and Australian Women Against Rape (Perth) organised a publicised 24 hour 'phone-in' designed to give women who had been sexually assaulted an opportunity to speak about their experiences. Of the 150 calls received, more than half related to intra-familial sexual abuse.

This group of women who headed up the phone-in and took calls, subsequently formed self-help and support groups after identifying that most of the women callers had been silenced and not supported by their families and loved ones. Many callers were profoundly depressed and had a mental health diagnosis.

Individual counselling, as well as group counselling, commenced shortly thereafter, initially on a volunteer basis. Incest Survivors' Association Inc. (ISA) was formally incorporated in 1984 after obtaining a grant to provide services. ISA was the first Non-Government Association to deal specifically with child sexual abuse and the associated post-traumatic stress disorders and related psychological, emotional, relationship and wellbeing challenges.

It was common for women in that period of Australian history to establish services for sexual abuse and domestic violence with funds they had raised themselves and to work in those services on a volunteer basis. These were services that were not being provided by the Government of the day however, would be considered at this point in time as essential services particularly, for vulnerable women and children escaping abuse and violence. Research studies into child sexual abuse and domestic violence have highlighted that these experiences are at times linked and do not necessarily exist exclusively in isolation from each other. Women advocates, volunteering and lobbying separately in those two areas of social need, often joined forces to establish services, share scarce resources and collectively advocate for social justice.

In 1986 the Western Australian Government began partial funding of the Association to provide services to the community, recognising that the thousands of annual phone calls identified a large, hidden, community problem. From this time onwards this funding allowed services to become increasingly professionalised with paid staff required to have formal tertiary qualifications. Quality control measures were established through mandatory clinical supervision to support the worker's wellbeing and foster further skill development. Clinical Supervision also provided a monitoring process for promoting ethical high quality service delivery that was immersed in trauma informed practices.

ISA now operates as a Non-Government, Not-For-Profit charity. ISA currently has a contractual agreement with the WA Department for Child Protection and Family Support (CPFS) that provides approximately 90% of our funding. The remainder of funds are sourced from client fees, service fees, donations and memberships.

ISA has expanded its services to include public talks, training and education, a resource library, and a website and has produced over time newsletters and professional journals.

In the words of an ISA Client:

"For me, it was the knowledge that the right kind of help (ISA) was out there after three prior attempts with therapy with other professionals over the years"

ISA's Purpose & Evolution

ISA's original purpose was to respond to Intra-familial child sexual abuse (or incest as it was more commonly referred to when the organisation was first established). Over time and due to a needs and requests for help ISA services expanded many years back to include anyone who has experienced child sexual abuse inside or outside the family, but usually perpetrated by someone in whom they had placed their trust or who had authority over them. Child Sexual Abuse perpetrated by a stranger or someone not known to the child was minimal in comparison to the number of offenders who were, and is reflective of the grooming process. Support is also provided to the non-offending family, friends and significant others of those affected by child sexual abuse. Occasionally treatment may be provided for an offender who has been a victim of child sexual abuse. Due to ISA's organisational size and limited capacity this treatment is more likely to be available to a family with a child who is sexually acting out inappropriately as a consequence of being sexually abused so as to intervene early to prevent future offending or re-victimisation. Offering a service for this particular need and client group is always assessed on a case-by-case basis and there are a range of criteria that have to be met and safety strategies in place before any support is provided.

In the 2015 Report for Adults Surviving Child Abuse (ASCA) Pegasus Economics estimates that if the impacts of child sexual abuse (sexual, emotional and physical) on an estimated 3.7 million adults are adequately addressed through active timely and comprehensive intervention, the combined budget position of Federal, State and Territory Governments could be improved by a minimum of $6.8 billion annually. This estimate could rise to $9.1 billion if these figures included up to 5 million adults.

The ASCA Report states that when survivors comprehensively overcome their trauma they and their children are freed to live productive, healthy and constructive lives. Their children too benefit, because the resolution of trauma in parents can intercept its transmission to the next generation. People affected by child sexual abuse and its associated trauma impacts incur significant costs on taxpayers. This occurs through higher Government expenditure on health spending, welfare support and criminal justice costs, as well as via lower taxation revenue. A key by-product of addressing these childhood trauma impacts is a financial benefit to Government budgets and the broader community.

The work of the Royal Commission in bringing to light the issue of child sexual abuse has been pivotal, timely and invaluable. This inquiry has created a public and media discourse about the extent of child sexual abuse in our communities. In addition, we have seen the lack of awareness and understanding highlighted along with the ongoing blaming of victims while excusing offenders who far too often avoid responsibility and accountability. The failure of institutions to respond adequately, or at all is clearly evident. Importantly, it has also become evident there has been a failure by society to protect it's most vulnerable from sexual abuse. There is still a long way to go in eradicating this scourge and shame on our nation. It is unacceptable and a major concern that child sexual abuse is still more prevalent in the sanctity of the family home than in institutions. Homes are not necessarily the safe havens we have purported them to be and this is where victims are groomed and offenders are grown.

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ISA responses to aspects of the online survey

TOPIC A:
What services do you think survivors need but are not currently available?

- Easy access to legal counsel
- Support with submitting criminal injuries compensation claims
- Support with proceeding to criminal prosecution including all that is involved and being well informed about the risk of further trauma impacts from the process
- If a survivor does proceed to criminal prosecution having access to legal representation, witness preparation and protection if necessary, access to a court support advocate along with access to free or low cost counselling before, during and after the proceeding to minimise the further trauma impacts from the system.
- Access to a greater number of healing modalities for treating complex trauma e.g. mindfulness based therapies, bodywork therapies, expressive therapies
- Free or heavily subsidised counselling, support and advocacy services in recognition that complex trauma requires access to long-term support
- Counselling services to meet demand especially in rural and remote locations
- A 24 hour telephone counselling and advocacy support helpline with personnel trained specifically to respond to those who have experienced child sexual abuse and particularly to offer support when they are in crisis as a result of their trauma responses being triggered.
- Trials to explore and develop alternative therapy options, such as e-counselling, recognising there are specific complexities and risks associated with these options, which need to be considered, with a view to developing practice guidelines for using this medium
- Peer support groups for both survivors and the non-offending family members
- Therapeutic support groups for those who feel ready to engage in group work
- Other 'wrap-around' supports for people who have experienced severe trauma, who are experiencing difficulties with day-to-day functioning which extends beyond the scope of counselling and can offer practical support and development of essential life skills
- Support for secondary/indirect survivors i.e. the families and significant others of those who have experienced child sexual abuse or non-offending members of families where an offender has been identified

Feedback from ISA Clients:

What services do you think survivors need but are not currently available?

"Support and knowledge in dealing with adult responsibilities. Growing up in an abusive household I don't have role models to teach me how to manage finances. Deal with car issues. I have often had no one to turn to for simple life knowledge."

"Awareness about the law in regard to child sexual abuse, how to identify risks in society and support others in the society."

"Low Fees, recovery is long term and caused by someone else."

"Some services do not offer long-term help or provide information compared to services that specialise in childhood sexual abuse."

"Fully subsidised support."

What makes it easier for survivors to access the support they need?

- Welcoming services
- An easily accessible service location that is also safe, secure and private
- De-stigmatising, easy referral pathways (such as self-referral)
- No waiting list or at a minimum a timely assessment to prioritise need
- A service that offers some anonymity in regard to the purpose of accessing such a service and avoids accidental disclosure
- Locally provided services
- Affordable services
- Community education and knowledge about the support survivors need and services that are available
- Raising awareness in the community of the prevalence and impacts of child sexual abuse and the profound effects this can have long-term and that recovery is a process that takes time
- Peer support and 'one stop' shop service centres

What are the barriers?

- Long waiting lists
- The cost of, and requirement for, a mental health care plan and GP referral – typically GPs have little experience in this area. ISA has received anecdotal evidence from clients about their negative experiences when approaching GPs as a first point of contact for a care plan
- Assessments or triage being conducted by professionals with limited training or skills in the specific area of sexual abuse trauma
- Cost of counselling
- Time-limited counselling
- Availability in local area
- Perceived stigma of requiring mental health services
- Lack of knowledge regarding available services

Feedback from ISA Clients:

What are the barriers to receiving advocacy and support and/or therapeutic treatment?

"Recovery is lifelong and services need to be long term and affordable. Early exit contributes to on-going abuse by the system".

"The largest barrier for me has always been the referral to treatment. General Practitioners have often turned me away and offered no course of support. In the past, finances have also been a barrier i.e. treatment costs, transport etc."

"Long waiting lists, busy institutions, as there are so many clients, changes in counsellors."

"Fear of judgement and breach of privacy. Shame around the story."

"Availability of highly trained therapists and low cost therapy."

"The only barriers are ourselves."

"Fear of 'coming out' and dealing with something that you have not shared with anyone previously."

How might those barriers be addressed?

"ISA have helped immensely with sliding fees and offering phone sessions if required."

"Immediate attention. If long waiting list, refer to another institution. On call counsellor - for immediate support. Try to provide the same counsellor if client happy."

"Counsellors and support workers properly training in trauma. Engage in own work."

"Target some of the Mental Health funding (both State and Federal) to this specific community. Train more professional."

"More public awareness regardless of the discomfort it may cause."

"By the caring staff."

"More liaison with a wide range of health professionals about how they might play a role in facilitating such a decision by a victim."

What types of services work well to help survivors?

- Trauma-informed specialist services, with easy access
- Services that offer choices (of counsellors, therapeutic framework, mind and body needs)
- Local, available and low cost (recognising counselling is generally long term)
- Flexible services with no time-limits and ability to take breaks from the therapeutic work and then reengage as needed and as many times as considered necessary

Feedback from ISA Clients:

"Having one person in your support system that is consistent and accepting has been a huge change for me. Reaching out and reorganising appointments has helped me stay in treatment."

"Having people, family members, friends to support this process."

"Strengthening secondary victims, strengthening primary victims, providing support with ongoing issues."

"Genuine care and relationship with counsellor, consistency and reliability of services. Good boundaries."

"Access to services in a timely manner, discreet support."

"Non judgemental, Time – allowing survivor to go through processes in own time."

"The privacy, knowing you can be there and feel safe."

"Recognition of these survivors, and to increase the awareness, understanding, and acceptance of them in society. It is also paramount that their experience and recovery is respected and kept private."

"Personally I've found that long-term services that fit within my other responsibilities has benefitted me the most (as opposed to intensive short term treatment)."

"Lots of psychological support."

" Interpersonal relationships, trauma therapy, safety, coping strategies, psycho education, Schema work."

"Specialist services – professionals who are highly experienced in working in this field."

"Talking about it"

"Psychotherapy and information."

"Kind and caring therapist. The inconspicuous building."

"One to one counselling and support."

Feedback from ISA Clients:
What does not work or can make things worse for survivors?

"Treatment that only focuses on the trauma and not the current or 'unrelated' issues. Positive and forward focused treatment between abuse specific treatments increases my general wellbeing."

"Not being heard by those who are meant to be there to listen and help (Department of Child Protection etc)."

"When survivors cannot approach the Service Provider – Institution busy. Being unable to attend, due to work and other affairs."

" Judgemental, inexperienced counsellor – unable to cope with traumatic stories. Bad boundaries. Inconsistent – lots of appointment cancellations."

"Stigma, judgement, lack of understanding about the perverse impacts of this trauma."

"Not being believed. Talking about it."

"If a counsellor/psychologist does not place relevant importance on child sexual abuse trauma history and also therapy is cut short due to costs."

"Any pressure put on the victims to declare themselves publicly or to feel that any treatment and support needs to be rushed."

TOPIC B:

What could improve the provision of services to survivors from diverse backgrounds, such as Aboriginal and Torres Strait Islanders or those from culturally or linguistically diverse backgrounds, or people with disability?

- Training professionals to engage and work with survivors from diverse backgrounds.
- Provide translations of key documents and access to a professional interpreter if necessary.
- Ensure buildings are accessible for individuals with disability
- Provision for free transport or petrol vouchers
- Raise awareness of disability issues in promotional material, appointment letters etc.
- Develop online resources and provision for tele-counselling for those unable to attend due to disability or living in rural location with practice guidelines in place for this medium
- Actively engage and involve members from Indigenous communities, make them visible in high status roles within the organisation, e.g. reference group; specialist advisor(s); member(s) of boards
- Use appropriate cultural symbols such as the Aboriginal flag and pictures (some good ideas were reported in media releases for the mental health week)
- Having a diverse range of professionals trained to work with complex trauma so that survivors have a choice as to whether they work with a professional from their own cultural or religious context; or the option to seek support outside of that as there may be concerns in regard to confidentiality and privacy, or concerns about a lack of understanding about child sexual abuse within their culture or religious dogma.

Feedback from ISA Clients: *See Appendix 1 for further feedback from clients*

TOPIC C:
What challenges do service providers face in responding to survivors needs in regional, rural or remote areas?

- Client isolation and professional isolation
- Social pressures on people not to disclose, particularly when the perpetrator is a well-liked or well-connected member of the community, including fear of denial, disbelief, fear of retribution, victim-blaming or being excluded from their community as a result of disclosure
- Safety issues when doing trauma work with individuals with high levels of emotional distress, particularly when perpetrators may still be living and/or actively offending within the local community
- Access to suitably qualified professionals and specialised mental health services
- Generalist counsellors may not be equipped to recognise signs of complex trauma and risk factors, or know how to respond appropriately and effectively
- Confidentiality when accessing services especially in small towns – particularly where there may be a small number of health providers or counsellors who have links to the community and may even have social connections to clients or offenders or their families
- Ability to provide outreach programs
- Assistance with transportation to regional services
- Recruiting staff to work in rural areas; access to adequate training and supervision

What would help providers in supporting survivors?

- Funding directed at providing specific services in rural areas
- Development of online resources and tele counselling services
- Involvement with local health care services to reduce isolation
- Funding for specialist services to provide training to rural health providers
- Funding for specialist providers to travel to rural areas to provide anonymous 'pop-up' services

Feedback from ISA Clients: *See Appendix 1 for further feedback from clients*

TOPIC D:

What do practitioners (that is, those working in advocacy and support and therapeutic services) need in order to meet the needs of survivors of child sexual abuse?

- Training to update skills regularly to keep up with new trends and latest evidence based programs and good practice
- Opportunity to network with others working in the field of complex trauma
- High quality regular supervision with opportunity for clinical observations and feedback on practice, including case note audits
- Funding to conduct action based and other forms of research to further develop the effectiveness and efficacy of complex trauma work
- Experience and maturity in dealing with complex trauma
- A review of best practice and the legal implications for case notes in regard to clients seeking treatment for child sexual abuse.
- The criminal nature of child sexual abuse means in effect practitioners potentially are collecting and recording what could be considered evidence that may end up in a criminal proceeding. In effect a practitioner may change evidence through their interpretation of the client's narrative provided, and the notes the practitioner records as a recollection of that narrative.
- To avoid this ISA would recommend greater provisions should be considered for protecting client records. Allowing privileged information in to a court proceeding in effect can allow an offender to literally become a 'voyeur' of the counselling sessions that took place and this could become a major deterrent for survivors accessing counselling.
- If an offender and/or their legal representative has access to these records then the information contained in the client's file could be used in an attempt to discredit the witness particularly, if common impacts of complex trauma addressed in therapeutic treatment such as self harm, suicidal ideation, substance abuse, mental health challenges etc were exposed

Feedback from ISA Clients: *See Appendix 1 for further feedback from clients*

TOPIC E:

What innovative practices in the provision of advocacy and support and therapeutic treatment services are emerging and what are the learnings from these practices?

- Use of expressive therapies including art therapy and mindfulness practice. Therapists need to be multi-skilled (trained) in order to meet the varied and individual needs of each client.

- Use of body therapies such as yoga and other modalities known to be effective for enhancing relaxation and releasing tension and stress and trauma impacts held in the body.

- Assessment for self-regulation challenges and exploration of strategies that would assist the client to address hyper or hypo aroused states to facilitate a greater sense of wellbeing and to reduce anxiety

- Use of treatment models that approach the person holistically and take a mutli-level and multi disciplined approach to address all the impacts of trauma including physical not just psychological.

- Clients may benefit from improvement to their nutritional intake, level of exercise, sleep hygiene etc by providing them with the latest information about the importance of these for enhancing their overall wellbeing and their recovery through the therapeutic treatment.

- Teaching relaxation and meditation techniques

Is there anything else you'd like to tell us about advocacy and support and therapeutic treatment services?

Systemic advocacy:

While individual support and individual advocacy go hand in hand, there can be an inherent tension between individual support and systemic advocacy.

While efforts to raise awareness about the issue of sexual abuse can help reduce the stigma of abuse and encourage people to seek help, this can also be highly triggering for people who have experienced abuse. For example, ISA has received reports from clients and non-clients who have found some aspects of the reporting and public debate surrounding the Royal Commission and its work in the media to be highly challenging.

This presents a level of complexity for support organisations such as ISA, where our primary focus must always be on the health and wellbeing of our clients.

We would welcome specific funding to develop and focus on systemic advocacy to raise awareness of the issues as a way of encouraging and supporting people to disclose abuse and seek help, in a way that is mindful of and seeks to minimise re-traumatising people who have experienced abuse.

Prevention:

ISA is also interested in preventing future cases of child sexual abuse, and has begun discussions with providers of domestic violence services, as we believe children who have experienced violence in the home are more at risk of becoming victimised and some may also become offenders in later life, as a way of acting out their earlier abuse. We would welcome support to develop interventions to disrupt this cycle of intergenerational trauma.

Being fortunate to have had a key advisory role in the development of the Western Australian Government's 'Freedom From Fear' campaign that targeted perpetrators of family violence I was able to see first hand what can be achieved with an effective communication message. This media and educational campaign focused on the impact on children of witnessing and/or experiencing violence. A Men's Domestic Violence Helpline was established as a call to action to address their use of violence through telephone counselling and accepting referral's into 6 month treatment and behaviour change programs. A significant number of men contacting the helpline subsequently accepted a referral and volunteered for treatment. This was a highly successful campaign that raised awareness, and focused on children often the silent and forgotten voices. The campaign was awarded the WA Premier's Award and other international awards however, although government was warned, due to the unexpected high-level demand for services and the associated costs the campaign eventually ceased. Need I say more, as we are all too aware of how this type of story ends all too often with the 'pilot' project being the classic example.

Australia needs bi-partisan support by Government to commit to adequate and long-term resourcing that is not dependent on election cycles if we are truly to succeed in the prevention of child sexual abuse and violence in the home, our communities, and our institutions. This is the only way we will effectively reduce the long-term and devastating inter-generational impacts of these experiences of terror and trauma. ISA supports the notion that child sexual abuse is a form of domestic violence. It makes little sense that with such community outrage and fear in response to terrorist attacks there is little discourse about the parallels that exist in Australian homes where adults and children are being held captive and terrorised frequently, and more often now dying in a similar way at the hands of those who use violence while at the same time professing their love. The Nobel prize winning economist James Heckman in his research provided evidence that returns for dollars invested in early childhood provided significant savings in dollars later and contributed to less unemployment and welfare costs, less need for out of home care, less crime and incarceration rates, and a whole range of other social benefits.

ISA's Transition To A New Name

As a result of feedback from ISA clients and our key stakeholders and partners in the community, a process began several years ago to consider a new name for our organisation. The existing name is not reflective of the broader range of services now delivered by ISA. A rationale also presented to ISA was the term 'incest' was no longer commonly used given a growing trend toward using the term child sexual abuse.

In addition, clients have expressed a desire to ISA to access a service where the name provides some anonymity for them. It was also agreed that the organisation needed a name that was more reflective of our current services and the broader group of clients we are seeing who have experienced child sexual abuse by non-family members and often perpetrated by people who were in a position of trust. Sadly in some cases it was not one or the other but both. Children being sexually abused within a family became vulnerable to being re-victimised by others outside the family.

So following much deliberation over a long period of time, and a consultation process that was undertaken in earnest between March & June 2015, the current Executive Officer and the ISA Board at their meeting in August 2015 approved a change of name. In early 2016 ISA will transform and become known by a new name ***PHOENIX SUPPORT & ADVOCACY SERVICE***. This decision was not taken lightly, but was seen as responsive to feedback from our key stakeholders, particularly our clients, and we think an apt name for symbolising the transformational journey of healing and recovery and the long-term effort required to rise from the ashes of the devastating impacts experienced from child sexual abuse. The coincidental synchronicity of this name having a connection to the most recent Issues Paper from the Royal Commission into Institutional Responses to Child Sexual Abuse in some respects affirmed the decision.

About ISA's Future Direction

The Incest Survivors' Association Inc. (Phoenix Support & Advocacy Service) is keen to expand, refine and continually improve our services and the support we provide to clients, their significant others and the broader community. We will endeavour to be a voice at the table where it matters. An ongoing challenge for a service such as ours is we have not been able to secure the funding we require to build capacity. There is so much potential for a service such as ISA/Phoenix however, much of the time and energy of Board members and the Executive Officer (employed part-time) is focused on fundraising and sustainability where this time and effort could be better utilised on the implementation of improvements to service delivery, strategic plans, advocacy, community education, training other professionals and continuous improvement.

There seems to be a movement towards mergers and acquisitions when in fact it is an organisation such as ISA/Phoenix that should be leading the charge in responding to child sexual abuse with more than 35 years of dedicated service and with a growing knowledge base and developing expertise despite limited funding. Clients are clear that it is only when they access a specialised service such as ISA/Phoenix that they receive the long-term support and understanding they have been seeking, but have not been able to find in mainstream services delivered by mainstream agencies. ISA/Phoenix is also a survivor of funding cycles, but we need the Government and the community behind us if we are to continue to survive and thrive.

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Appendix 1: Feedback from ISA Clients - Issues Paper 10

Royal Commission into Institutional Responses to Child Sexual Abuse

What do you consider to be important and helpful in terms of advocacy and support for survivors?

Client A:

Having one person in your support system that is consistent and accepting has been a huge change for me.

Reaching out and reorganising appointments, has helped me to stay in treatment.

CLIENT B:

HAVING PEOPLE – FAMILY MEMBERS – FRIENDS TO SUPPORT THIS PROCESS.

Client C:

1. **Strengthening secondary victims.**
2. **Strengthening primary victims – providing support with on-coming issues.**

Client D:

Genuine care and relationship with counsellor, consistency and reliability of services. Good boundaries.

Client E:

Support - access to services in a timely manner - discreet support.

Client F:

N/A

Client G:

Non-judgemental
Time – allowing survivor to go through processes in own time.

Client H:

The privacy. Knowing you can be there and feel safe.

Client I:

Recognition of these survivors, and to increase the awareness, understanding, and acceptance of them in society. It is also paramount that their experience and recovery is respected and kept private.

What kind of therapeutic treatment services work best for survivors?

Client A:

Personally I've found that long-term services that fit within my other responsibilities has benefited me the most (as opposed to intensive short-term treatment).

CLIENT B:

N/A

Client C:

Lots of psychological support.

Client D:

- **Interpersonal relationship.**
- **Trauma therapy, safety. Coping strategies**
- **Psycho education.**
- **Schema work**

Client E:

Specialist services – professionals who are highly experienced in working in this field.

Client F:

Talking about it.

Client G:

Psychotherapy and information.

Client H:

Kind and caring therapist. The inconspicuous building.

Client I:

One to one counselling and support.

What does not work or can make things worse for survivors?

Client A:

Treatment that only focuses on the trauma and not the current or 'unrelated' issues. Positive and forward focused treatment between abuse specific treatments increases my general wellbeing.

CLIENT B:

NOT BEING HEARD BY THOSE WHO ARE MEANT TO BE THERE TO LISTEN AND HELP DEPARTMENT OF CHILD PROTECTION ETC.

Client C:

When survivors cannot approach the Service Provider –

1. **Institute busy.**
2. **Being unable to attend, due to work and other affairs.**

Client D:

Judgemental. In experiences of counsellors – unable to cope with traumatic stories. Bad boundaries. Inconsistence – lots of appointment cancellations.

Client E:

Stigma, judgement, lack of understanding about the perverse impacts of this trauma.

Client F:

Not being believed. Talking about it.

Client G:

If a counsellor/psychologist does not place relevant importance on child sexual abuse trauma history and also therapy is cut short due to costs.

Client H:

No

Client I:

Any pressure put on the victims to declare themselves publicly or to feel that any treatment and support needs to be rushed.

Can you think of anything that survivors need from services but do not easily receive?

Client A:

Support and knowledge in dealing with adult responsibilities. Growing up in an abusive household, I don't have role models to teach me how to manage finances. Deal with car issues. I have often had no one to turn to for simple life knowledge.

CLIENT B:

NO, HAVE ONLY JUST STARTED THIS PROCESS.

Client C:

Awareness about law in regard to child sexual abuse, how to identify risks in society and support others in the society.

Client D:

Low fees, recovery is long term and caused by someone else

Client E:

N/A

Client F:

N/A

Client G:

Some services do not offer long-term help or provide information compared to services that specialise in childhood sexual abuse.

Client H:

N/A

Client I:

Fully subsidised support.

What are the barriers to receiving advocacy and support and/or therapeutic treatment?

Client A:

The largest barrier for me has always been the referral to treatment. General Practitioners have often turned me away and offered no course of support.

In the past, finances have also been a barrier. (Treatment cost/transport etc).

CLIENT B:

COST.

KNOWLEDGE.

AWARENESS OF PROGRAMS

Client C:

Long waiting lists.

Busy institutions, as there are so many clients.

Changing the Counsellor.

Client D:

Fear of judgement and breathe of privacy. Shame around the story.

Client E:

Availability of highly trained therapists and low cost therapy.

Client F:

N/A

Client G:

For me, it was knowledge that the right kind of help (ISA) was out there after three prior attempts with therapy with other professionals over the years.

Client H:

The only barriers are ourselves.

Client I:

Fear of 'coming out' and dealing with something that you have not shared with anyone previously.

How might those barriers be addressed?

Client A:

ISA have helped immensely with sliding fees and offering phone sessions if required.

CLIENT B:

NOT SURE

Client C:

Immediate attention. If long waiting list, refer to another institution.

On call Counsellor – for immediate support.

Try to provide the same Counsellor, if client happy.

Client D:

Counsellors/support workers properly trained in trauma.
Engage in own work.

Client E:

Target some of the Mental Health funding (both State and Federal) to this specific community.

Train more professionals.

Client F:

N/A

Client G:

More public awareness regardless of the discomfort it may cause.

Client H:

By the caring staff.

Client I:

More liaison with a wide range of health professionals about how they might play a role in facilitating such a decision by a victim.

Fear of 'coming out' and dealing with something that you have not shared with anyone previously.

How well do advocacy, support and/or therapeutic treatment services currently respond to the needs of secondary victims? (e.g.: partners / non-offending family members / friends)

Client A:

Very well for me. Services for both my partner and daughter have been offered to me.

CLIENT B:

I CAN ONLY SPEAK FOR THIS SERVICE ISA. ISA HAVE GIVEN MANY HELPFUL SUGGESTIONS FOR FAMILY AND FRIENDS.

Client C:

Some institutions support actively. Client is healed and strengthened to go ahead.

Client D:

Services are available, perhaps advertising.

Client E:

N/A

Client F:

OK if others stay around for support.

Client G:

No experience with this, but the Peer Support Programme at ISA sounds great.

Client H:

N/A

Client I:

In my experience, not much support at all

How could services be shaped so they better respond to secondary victims?

Client A:

N/A

Client B:

Not Sure

Client C:

Family counselling, information about providing on-line software.

Client D:

N/A

Client E:

N/A

Client F:

N/A

Client G:

Again maybe more public awareness for their part in it all.

Client H:

N/A

Client I:

Perhaps in the initial consultation, identify who are the secondary victims and bring them later into the counselling sessions if necessary. More resources (one to one, online) for those wanting more help.

Do you think that services adequately cater for linguistically and culturally diverse survivor groups? If yes, please describe the aspects that you think work well.

Client A:

N/A

CLIENT B:

UNSURE.

Client C:

Provide material in simple language.

Talk or understanding simple English.

Client D:

N/A

Client E:

N/A

Client F:

N/A

Client G:

N/A

Client I:

My counsellor was also an immigrant; therefore she was sympathetic to my particular situation.

How could the needs of victims and survivors from diverse backgrounds be better met?

Client A:

N/A

CLIENT B:

UNSURE.

Client C:

N/A

Client D:

Availability of more interpreters. Cultural awareness for workers.

Client E:

Interpreters trained to work alongside client/therapist in counselling environment.

Cultural competence for professions.

Client F:

N/A

Client G:

N/A

Client I:

I feel it is essential to bring in more counsellors from various cultural backgrounds as Australia is such a multicultural nation – not only cultural awareness but also linguistic awareness helps a lot in consultation.

What can be done to help individuals who live in rural areas to access services?

Client A:

N/A

CLIENT B:

AS I HAVE LIVED RURALLY FOR MANY YEARS, THIS IS A BIG ISSUE!

I CAN'T OFFER MANY SUGGESTIONS, BUT KNOW THIS NEEDS TO BE LOOKED AT! MAYBE FUNDING FOR COSTS TO GET TO

PERTH, MORE PROGRAMS RUN IN SCHOOLS ETC.

Client C:

1. **Having a Counsellor in a community centre according to the requirements.**
2. **Over the phone or Skype.**

Client D:

Internet counselling – Skype.

Outreach.

Client E:

E health technologies.

Specialist services that can operate in flexible ways (outside of rigid guidelines) to customise service to meet local needs.

Client F:

Government support for petrol.

Client G:

Transportation.

Client I:

Perhaps, a well-designed and constructive on-line service could be a backup for personal meetings.

Do you think that the current language used to describe child abuse issues is appropriate, such as the terms 'victims' and 'survivors'?

Client A:

I have never felt offended by these terms. I think both have their place and neither instil responsibility and blame in victims.

Client B:

Yes.

Client C:

Yes.

Client D:

OK for now, until something better comes along.

Client E:

'Victims' – no
'Survivors' – yes.

Client F:

Don't like being called a "victim". It makes me feel lower than everyone else.

Client G:

Not victim so much.

Client H:

YES

Client I:

I think current terms are fine.

If not, what terminology and definitions are preferable?

Client A:

N/A

Client B:

Yes.

Client C:

N/A

Client D:

N/A

Client E:

Lived experience of child sexual abuse.

Client F:

I don't know.

Client G:

Survivor is good.

Sometimes think symptoms we have are (as adults) e.g. incest syndrome, but I guess that sounds negative, but it's true.

Client I:

N/A.

Are there practical or structural ways the service system can be improved so it is easier for survivors to receive advocacy, support and/or therapeutic treatment services they need?

Client A:

For me, I have found therapy with ISA to be invaluable. Gateway into treatment is the area that I feel is lacking GP's and hospital staff are insensitive at best and in my experience lacks the knowledge to refer clients to treatment.

Client B:

N/A

Client C:

Some General Practitioners are not aware about Institutions or Psychologists to refer a victim.

Client D:

Increase funding and services.

Client E:

Embrace peer designed services, co-production etc.

Client F:

N/A

Client G:

I haven't been in the system, but have a fair idea; I.S.A. is what should be aspired to.

If more awareness specialised treatment was available, would be good, however would then need to expand.

Client H:

GPs & Psych services need to know about this service.

Client I:

To recognise the demands on the caseworkers/counsellors by offering better wages, ongoing training and recognition for the nature of their work.

What type of service models (i.e. counselling approaches) help survivors to receive the support they need?

Client A:

I prefer counselling that is more humanistic. I often feel patronised when CBT approaches are used.

Client B:

N/A

Client C:

Children are not able to verbalise their emotions during the sessions. But they are holding fears, shyness. Play therapy would help them to articulate what is going on internally.

Client D:

Counselling.
Support.
Case management.

Client E:

Establish good relationships with client.
Whatever works – the therapist should have several tools.
Stay current with evidence based therapy, update every year.

Client F:

N/A

Client G:

Psychoanalysis.

Client H:

N/A

Client I:

Not enough experience/knowledge to determine this, but perhaps inclusion of art therapy or other models of hands-on therapy. Variation and flexibility are important, as recovery can be unpredictable.

Is there anything else you would like to add about advocacy and support and therapeutic treatment services?

Client A:

N/A

Client B:

They are hard to find.

Client C:

Communicate with the Counsellor, emails about issues before you come to sessions.

Client D:

Recovery is lifelong and services need to be long term and affordable. Early exit contributions to on-going abuse by the system.

Client E:

Thank goodness they are available. PS without them suicide rates may increase.

Client F:

Meeting with other people with similar or same past from care homes.
To talk about bad things and good things in care homes.

Client G:

More public awareness might bring more sponsored funding.

Client H:

N/A

Client I:

To more thoroughly research and implement advocacy branding that emphasises treatment and services in a very positive light would be great.