

# **Children in State Care Commission of Inquiry**

**Submission by  
Relationships Australia (SA)**

**April 2007**

# Children in State Care Commission of Inquiry: Submission by Relationships Australia SA.

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# 1. Introduction

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## 1.1 *About Relationships Australia (SA)*

Relationships Australia (SA) offers a high level of skill in the provision of services in the areas of counselling, community education and professional training. RA (SA) is a non government, not for profit agency which has not been a provider of State Care services to children, nor linked to any church. As such the agency is able to assure people that in the area of childhood sexual abuse it is free from conflict of interest and able to offer clients an independent service.

RA (SA) offers a diverse range of services to meet the needs of many different individuals and groups, to promote wellbeing and positive relationships. Its largest area of service delivery is its Family Relationship Services, funded by the Australian Government. This includes relationship counselling, post-separation services, mediation, relationship education and a children's contact service. Its Family Relationship Centre began in July 2006 to provide relationship support, advice, and information for individuals, couples and families on a range of relationship issues. One of its important roles is to provide family dispute resolution to help separating families reach agreement on parenting arrangements.

RA (SA)'s MOSAIC service promotes the emotional and mental health of people affected by HIV or Hepatitis C, with free and confidential counselling, information and referrals to relevant community or health services. Individuals from culturally and linguistically diverse (CALD) communities are supported by the PEACE Multicultural Services and RA (SA)'s Break Even Gambling Rehabilitation service helps people with problem gambling.

In 2005 the agency opened a new training centre, *The Australian Institute of Social Relations (AISR)*, which has received Federal funding to become the first specialist training centre to provide training to community services and health sectors on issues such as domestic violence, sexual abuse, youth work, community development and social health. The Institute has significant experience in developing and providing training in these areas and led the development of the nationally significant resource *Point of Contact: Responding to Children and Domestic Violence*, funded by the Commonwealth Government under the Partnerships Against Domestic Violence. This comprehensive training resource of 10 booklets was developed and trialled in extensive consultation with frontline workers from a range of workplace groups whose work involves responding appropriately to children who have been living with domestic violence.

In the past year the AISR collaborated with the Family Court of Australia on domestic violence risk assessment and developed a training package for general practitioners on mental health, suicide prevention and responding to domestic violence.

Relationship's Australia (SA)'s services and training programs are provided, not only in the metropolitan area, but also in rural and remote areas and to Indigenous populations. For example, we provide nationally recognised training to youth workers in a number of communities across the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. Staff members visit the APY Lands on a four to six weekly cycle to deliver workshops, provide mentoring, formally assess and offer support to youth programs. Students include both Anangu and non-Indigenous people. Our Riverland services extend from Renmark to Waikerie and include relationship counselling, relationship education, mediation and primary dispute resolution, gambling rehabilitation and a Victim Support Service.

In making this Submission, Relationships Australia (SA) draws on our experience in providing these and many other client services and professional training programs, and in particular our service for adults sexually abused as children: *Respond SA*.

## 1.2 About Respond SA

The South Australian Government demonstrated its concern and determination to address child sexual abuse when in June 2004 it established *Respond SA*. This initiative is funded through the Department for Families and Communities until December 2007. The impetus for the creation of this service was, initially, the recognition of the numbers of children sexually abused while in State care and the consequent effects of these crimes in later life. However, from the outset it was recognised that the sexual abuse of children occurs in many different settings and thus *Respond SA* has a broader brief to meet the significant unmet need of all adult survivors of child sexual abuse. The *Respond SA* service provides for the following client groups:

1. Adults (16 years and over) who have been subjected to childhood sexual abuse
2. Their families and significant others
3. Workers and agencies working with or responding to the client group.

*Respond SA* provides the following services:

- a. Telephone Helpline
- b. Therapeutic services (specialist face to face counselling)
- c. Referrals
- d. Groupwork
- e. Training and Workforce Development
- f. Policy Advice
- g. Partnerships with other service providers.
- h. Research
- i. Resource Development
- j. Community Education

### a. Helpline

The telephone helpline provides support, information and counselling to callers. Approximately 75% of callers to the Helpline have been people subjected to childhood sexual abuse, with family or friends comprising another 12%, and the remainder being allied professionals e.g. service providers. As of 30 June 2006:

- 2,244 client callers had contacted the Helpline service since the service began in July 2004. 71% of these were female and 29% male.
- The vast majority (77%) of survivors calling the Helpline disclosed that they were sexually abused within their families
- 5% of survivors disclosed sexual abuse whilst in Institutional or Residential care
- 2% disclosed sexual abuse by a member of the clergy
- 6% were sexually abused by an 'authority figure' (non-family member) e.g. teacher
- 8% were sexually abused by an 'acquaintance' (non-family member)
- 3% were sexually abused by a stranger.

### b. Therapeutic services

Our counselling services are provided at five Relationship Australia (SA) offices in the city and suburbs as well as outreach locations at an additional seven sites, including four community health services and three remand centres/prisons. Our counselling services are provided predominantly by *Respond SA* staff, with a small number being brokered out to suitably qualified private practitioners registered with *Respond SA*.

As of 30 June 2006, 977 clients had attended a booked counselling appointment with *Respond SA* staff or private practitioners, with a total of 3412 counselling sessions being provided since the service commenced.

This figure included the funding of 314 sessions with external counsellors for 46 clients, an initiative developed in response to the high demand for ongoing counselling services and *Respond SA's* growing waiting list. Brokerage counselling services are available in a number of metropolitan areas, including Yatala prison and the Adelaide Remand Centre, and in several rural areas. 25 external counselling sessions were provided to survivors of childhood sexual abuse who live in rural South Australia.

We have also responded to requests from the Children in State Care (CISC) Commission of Inquiry to register private counselling practitioners interstate for people who were sexually abused while in State care in South Australia and who have participated in the CISC Inquiry, but reside interstate. As of 30 June 2006, 78 counselling sessions have been provided in Queensland and NSW to such clients. In 2007 this service was increased to include counselling services for residents of Tasmania and the ACT.

**c. Referrals**

*Respond SA* receives referrals from a wide range of sources – people who have been subjected to childhood sexual abuse, their families, government services (including the SA Police Sexual Crimes Investigation Branch), non-government agencies and church groups. *Respond SA* also makes referrals to a range of service providers.

**d. Groupwork**

*Respond SA* has continued to work in partnership with other organisations to provide an extensive groupwork program for survivors of childhood sexual abuse. Groups have included four eight week women's groups in the northern and southern suburbs and one in Murray Bridge, one eight week men's group, and another ongoing monthly men's group.

**e. Training and workforce development**

*Respond SA* is continually consulting with key government and non-government organisations with interest and expertise in the area of child sexual abuse, in order to ensure a coordinated response which does not duplicate existing training and looks to improving workforce capacity. Initiatives have included:

- Production of two Interagency Training Calendars, which map the programs available in the state that are aimed at skilling a workforce to respond to violence and abuse.
- Workforce training initiatives in areas of particular disadvantage, including institutional care settings, disability services, Aboriginal housing, homelessness work, Children in State Care Commission of Inquiry, Juvenile Justice services, CALD services and Aboriginal youth workers on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. A total of 32 programs have been delivered, with participants numbering 582.
- Capacity building initiatives in mental health services. In particular, *Respond SA* has supported training for a group of people who are interviewing mental health consumers with a history of complex trauma about their recommendations for service improvements.
- Financial support and training input to a men's childhood sexual abuse training program.
- Specific programs for workers with young people in secure care and transitional accommodation settings as part of the Certificate III & IV Youth Work run by the *Australian Institute of Social Relations* for Families SA.
- Membership of the Advisory Group for the Care of Adult Survivors of Childhood Sexual Abuse in General Practice Project. A *Respond SA* male counsellor has also contributed to this partnership project by interviewing men who have been subjected to childhood sexual abuse and facilitating a focus group regarding their experience of disclosing childhood sexual abuse to doctors.

- *Respond SA* has a close working relationship with the Commission of Inquiry into Abuse of Children in State Care and has provided three training programs for new staff, addressing sexual abuse of children in state care.
- *Respond SA* and Women's Health Statewide have formalised a training partnership and co-facilitated eight 'Foundation knowledge – working with adults who have been subjected to CSA' and 'Applying knowledge' training modules in Adelaide and rural locations.
- *Respond SA* staff are highly experienced in individual and group work and have developed a specialised two day training program in this area. To date this program has been run for workers in Mt Gambier.

Specific training initiatives have been developed to improve services to the following specific populations:

- *Indigenous people.* For example, we have provided statewide Aboriginal Youth worker training about childhood sexual assault in Pt Augusta, Ceduna, Murray Bridge, as well as Youth worker training in Pukatja and Kalka on the APY Lands.
- *People in prison.* Outreach counselling services have been provided at the Adelaide Remand Centre, Yatala Prison, Mount Gambier Prison, Pt Lincoln Prison and Adelaide Women's Prison. Discussions continue with Department of Correctional Services (DCS) regarding the development and implementation of training programs specifically for workers in prison and correctional facilities.
- *Rural services.* We have provided training programs in Port Augusta, Whyalla, Mt Gambier, as well as outreach counselling in a number of rural areas (as mentioned above). The Whyalla training focused specifically on working with men who have been subjected to childhood sexual abuse.
- *Culturally and linguistically diverse communities.* A tailored training program was delivered for community educators employed by the P.E.A.C.E. (Personal Education and Community Empowerment) team at Relationships Australia (SA). This training provided information to workers with newly arrived communities and more established migrant communities about responding to disclosures of childhood sexual abuse in small group programs.
- *People with disabilities.* *Respond SA* has provided a specialised presentation to the SHine Program addressing sexual health work with people with disabilities.
- *Workers with homelessness.* *Respond SA* has provided a training program to RA's Hutt Street Centre workers and to staff of the Department for Families and Communities to enable them to better understand the links between childhood sexual abuse and homelessness.

#### **f. Policy Advice**

*Respond SA* reports regularly to the Department for Families and Communities regarding service provision, usage and service trends.

There have been regular meetings with Commissioner Mullighan and consultation and advice about a number of services such as witness support, historical provision of alternative care and past reports of childhood sexual abuse. The Manager of *Respond SA* has participated in several national conferences and forums regarding the most effective ways of meeting the needs of people who have experienced institutional care and implementing the recommendations of the Senate Committee's 'Forgotten Australians' report.

#### **g. Partnerships with other service providers**

*SA Police.* *Respond SA* has a positive working relationship with the SA Police Sexual Crime Investigation Branch (SCIB). Callers to the helpline and counselling clients are able to make an anonymous report to SCIB through *Respond SA*. This arrangement is a first in South Australia. As of June 2006, 165 reports of historical childhood sexual abuse have been made to SCIB through *Respond SA*.

*CISC Commission of Inquiry.* The CEO of Relationships Australia (SA) has the role of social worker to the Inquiry, and she and the Manager of *Respond SA* meet regularly with the Commissioner and Inquiry staff. The *Respond* Manager also regularly meets with the CISC Inquiry's Manager of Witness Support services. *Respond SA* continues to prioritise people who have been abused in State Care for counselling services and provides witness support for people while they participate in the Inquiry. As of June 30 2006, 85 callers to *Respond SA*'s Helpline had disclosed sexual abuse while in institutional or residential care. As mentioned previously *Respond SA* has also provided training for Inquiry staff.

*Respond SA* is a member of SSARG (Statewide Sexual Assault Reference Group) and NASASV (National Association of Services Against Sexual Violence). It collaborates in training and other projects with Women's Health Statewide, Yarrow Place, SHine SA, Uni SA, Dale Street Women's Health and Victim Support Service.

#### **h. Research**

*Respond SA* supports the need for a specialist CSA service to participate in and advocate for ongoing research in areas such as violence, abuse and trauma. In 2005 the management of Relationships Australia (SA) decided to fund a consortium of researchers to undertake a comprehensive research inquiry into client and worker experiences of disclosure and help-seeking among adult survivors of childhood sexual abuse. This significant research is due to be published in mid 2007 (Breckenridge et al. 2007 forthcoming)

In 2006 *Respond SA* commissioned research focused on service usage and client satisfaction with the service.

*Respond SA* staff often respond to requests from students and researchers to participate in research focused on working with people who have been subjected to complex trauma.

#### **i. Resource Development**

Numerous resources have been developed since the establishment of *Respond SA* in July 2004. These include:

- Development of a *Respond SA* website ([www.respondsa.org.au](http://www.respondsa.org.au))
- *Respond SA* service pamphlet
- Children in State Care Commission of Inquiry Support Information pamphlet (made in consultation with *Respond SA* clients who have participated in the Inquiry)
- Groupwork pamphlet
- Service posters
- Men's booklet (made in consultation with men who have been subjected to CSA). Due to be published in 2007.
- Information sheets for family members / friends of people who have been abused about how to respond to disclosures (currently being developed).

#### **j. Community Education**

*Respond SA* is committed to increased community education regarding childhood sexual abuse. Community education initiatives undertaken by *Respond SA* include the following:

- Development of a *Respond SA* website
- Presentations to numerous community groups such as community based forums, Rotary clubs etc
- Training and education programs provided to service providers
- Publication and Statewide distribution of a *Respond SA* Newsletter (2004)
- Development and distribution of numerous written resources such as pamphlets and booklets.

### **Service Constraints**

*Respond SA* has however been funded on the basis of short term contracts and the continued existence of the service beyond December 2007 is not assured. This places significant constraints on the service in relation to:

- The ability to assure clients of an ongoing support service
- The ability to assure other agencies of an ongoing service to refer clients to and receive training from.
- Limitations in developing service partnerships to reach particularly hard to reach groups of clients.
- Difficulties in staff recruitment and retention due to the short term nature of contracts.

Despite these constraints *Respond SA* has developed a committed team of workers and has been effective in the delivery of a wide range of services in both the provision of services to adults who have been subjected to childhood sexual abuse and policy and training support to assist other effective service delivery to this client group.

### **1.3 Scope, background and rationale of this submission**

**The main focus of this submission is to provide information to the Inquiry about childhood sexual abuse and its effect on all groups.** We believe that this is important in order to provide a wider context for consideration by the Inquiry in examining the specific needs of people who have been sexually abused whilst in State care. In addition the submission focuses on **the services required to respond to adults** who have been sexually abused and services for people leaving State care.

The implications of the research cited in this submission has implications for many of the issues on which the Inquiry has sought input. Rather than seeking to answer each and every one of these issues, this submission has focused on a broad response with a more detailed review of the implications occurring in the forthcoming verbal presentation by Relationships Australia (SA) and other discussions with the Commission.

This submission draws on documentation and research completed by Relationships Australia (SA) and in particular, *Respond SA* since its inception in 2004. This includes:

- *Respond SA* Service usage patterns and statistics (from the beginning of the service)
- Client views about the *Respond SA* service which were canvassed in a client satisfaction survey (2006).
- An Evaluation Report (2005) which assessed the delivery of the services *Respond SA* had been contracted to deliver and canvassed views from the sector about the appropriateness of the service model.
- Counsellor and client experience, reported in a research report commissioned by RA (SA): *Adults talking about childhood sexual abuse. Client and worker experiences of disclosure and help seeking.* (Breckenridge et al. forthcoming 2007)
- Literature reviews (contained in both of the above two reports)
- Regular professional meetings at managerial level with relevant stakeholders (SA and nationally)
- Foster carer training and resource development.
- Resources developed by Relationships Australia (SA) such as the national domestic violence training resource *Point of Contact*.

This submission is also informed by key national reports such as the Senate Committee report *Forgotten Australians* (2004) and relevant South Australian reports such as the Layton report *Our best investment* (2003) and the subsequent Child Protection Reform Program *Keeping Them Safe* (2004).

Our experience with child sexual abuse is drawn from the total population of adults sexually abused as children, and that breadth of experience is reflected in this Submission. Nonetheless, it is also the case that *Respond SA*'s work with clients, our research and our collaborations with other agencies, have provided particular insights into children abused in State care. As mentioned earlier, 85 callers to our Helpline disclosed abuse which occurred in Institutional or Residential care. Our social work and training roles with the Inquiry have also alerted us to many of the issues pertinent to state care.

Based upon our experience and research we argue that the sexual abuse of children in State care cannot be considered in isolation from childhood sexual abuse more generally. We know that the prevalence of child sexual abuse is high and that perpetrators are frequently family members or trusted people known to the family or people in a care-giving role, as is the case for many children in State care. **Any effective response to child sexual abuse therefore needs to take account of the needs of *all* children who are subjected to it.**

As the SA Government's *Keeping them Safe* report states:

*We take seriously our obligations under the UN Convention on the Rights of the Child to which Australia is a signatory. This means valuing children and young people as citizens of our community who need care and attention, but who are also entitled to the same consideration as all our citizens. We acknowledge the uniqueness and potential of every child (2004, p.6).*

For these reasons particular issues relating to abuse in State care are discussed in this Submission alongside other childhood sexual abuse issues.

**Note:**

Throughout this Submission reference to particular questions posed in CISC's *Issues Upon Which The Commission Seeks Submissions*, are indicated in bold and square brackets, eg. **[Issue 1]**. We do not deal with each section individually, nor do we discuss each question posed.

The abbreviation CSA is used as a convenient shorthand to indicate childhood sexual abuse.

## 2. Child sexual abuse issues

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### 2.1 *Preamble: About children*

Before considering issues relating to child sexual abuse it is important to discuss a few common assumptions about children and childhood and to clarify some principles underpinning RA (SA)'s response to a number of issues involving services for children, including those relating to childhood sexual abuse.

Attitudes to children and young people are not static, but have been shaped over time by social values and contexts. As attitudes change, so have structures and systems changed in response. These changes include the policies and legislation which create services and the recognition of the rights and entitlements of young people.

For example, in pre-nineteenth century Britain children were by and large regarded as the property of their father. Only in the most extreme cases of neglect or abuse would courts remove children from their father's care and they did not necessarily place the children with their mother (Scutt, 1983, cited in *Point of Contact: Booklet 5*, p.36). Later, in the nineteenth century, children were seen as needing special protection and welfare. By the twentieth century children came to be seen as independent human beings with rights not only to care and protection, but also to other rights such as 'freedom rights'. It has really only been in the last 40 years that a children's rights perspective has gained momentum.

The above timeline, of course, presents a predominantly Anglo Celtic perspective. It must also be remembered that Australia is a multicultural society and that Indigenous people have lived here for over 50,000 years. Different communities have unique histories, traditions and practices – including the ways in which children have been viewed and understood.

### 2.2 *Incidence and dynamics of childhood sexual*

#### *Prevalence*

For a more detailed summary of the incidence and prevalence of child sexual abuse see the *Respond SA Evaluation Report* (Breckenridge et al. 2005)pp. 13-17.

It is difficult to accurately measure the prevalence of child sexual abuse as it is often not reported for a range of personal and systemic reasons. Different research methodologies and data collection methods have also resulted in discrepancies in the statistics.

However, both international and Australian research studies reveal that child sexual abuse is an unacceptably common experience. Overseas studies estimate that prevalence rates are somewhere in the range of 20-35% for girls and 7-20% for boys.<sup>1</sup> Australian studies (e.g. Goldman and Goldman 1988 and Fleming 1997) have concluded that the incidence is in the vicinity of 20-27% for women and about 16% for men. Other studies suggest it is even higher than this.

#### *Indigenous communities*

There is considerable evidence that the incidence of child sexual abuse is especially high within Indigenous communities. In the Australian context a particular consequence of colonisation is that many Indigenous families are trapped within impoverished environments where ill health, substance abuse and lack of educational and employment opportunities have contributed to escalating interpersonal violence, including high rates of family violence and child abuse.<sup>2</sup>

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<sup>1</sup> For example, a national British representative study of 2,869 young people aged 18-24 years, found that 21% of girls and 11% of boys disclosed experiences of child sexual abuse (Cawson et al.2000).

<sup>2</sup> Gordon et al. (2002) refer to an "epidemic of family violence and child abuse in Aboriginal communities".

### *Children with disabilities*

Both Australian and international data suggest that children with disabilities are considerably more likely than other children to be sexually abused. Various studies have estimated that they may be between 2 to 4 times more likely to be abused and less likely to receive intervention that may mediate the effects into adulthood (Briggs 1995).

### **Perpetrators**

Child sexual abuse occurs most frequently within the immediate and extended family and is also perpetrated by friends, acquaintances and those in positions of responsibility/authority such as clergy, care workers and community volunteers.

*Respond* SA's own Helpline statistics for the period July 2004 – June 2006 revealed that where the relationship of the perpetrator to the client was known, the vast majority of perpetrators were immediate and extended family members (77%). Another 14% were acquaintances and authority figures the child knew and was encouraged to trust. Child sexual abuse perpetrated by strangers, members of the clergy and residential care workers accounted for only 10% of the sample of identified perpetrators. This is consistent with research (such as Kelly et al. 1991; Cawson et al. 2000 and Goldman and Goldman 1988).

We know from the research (and from our own client data) that most perpetrators of childhood sexual abuse are adult males.<sup>3</sup> There is also a growing awareness of sibling abuse and sexual abuse by young males under the age of 16 years. Most offenders engage in multiple offenders with multiple children.<sup>4</sup>

### **Secrecy surrounding abuse within the family**

Respect for the family as a fundamental building block of society and attitudes to children have resulted in widespread social disbelief and discomfort in acknowledging that sexual abuse has occurred within families or that family 'friends' or guardians could possibly do such things. Historically, notions of the privacy and sanctity of the family have been supported by the legal system and reinforced by the church and in counselling, education, the media and popular culture. There has therefore been a reluctance, especially in the past, to interfere and this is clearly evident in the experiences of adults who have been subjected to childhood sexual abuse.

The Senate Committee Report, *Forgotten Australians* observes that:

When faced with graphic descriptions of abuse and assault it is difficult to conceive that such actions were able to continue unchecked and unpunished...it was not an isolated one off occurrence, rather, it was endemic in some institutions over long periods of time. (p. 127).

Relationships Australia (SA) has exactly the same trouble in conceiving that the high prevalence of sexual abuse perpetrated against children has been, and still is, able to continue unchecked and unpunished. Our own experience of service delivery to clients who have experienced sexual abuse as children, and data from relevant research literature, confirms that the prevalence of this crime is shamefully high, under-reported and protected by veils of silence and disbelief. Recent attention to abuse within church settings has made some progress in this area, and similarly the existence of the CISC Commission of Inquiry has highlighted the extent of sexual abuse of children in state care. It is a concern however that the sexual abuse of children within their families continues to receive little attention.

<sup>3</sup> Kelly, Regan and Burton (1991) estimated that 85% of peer sexual abusers and 95% of adults who sexually abuse children, were male.

<sup>4</sup> For example a Canadian study (Abel et al. 1985) found that convicted male sex offenders reported an average of 533 offences and 336 victims each. This is consistent with Laing's data from the New South Wales Pre-trial Offender Diversion Program (1999).

Even when survivors are aware that the abuse was a crime, there are many reasons for non-reporting, for example fear, knowledge of the tactics that will be used by the perpetrator, ambiguous feelings about the perpetrator, shame, and lack of confidence in support options. Thus it was only in the mid 1980s that South Australia initiated the Childhood Sexual Abuse Taskforce which clearly highlighted the existence of sexual abuse of children. It should also be noted, of course, that the law allowing the reporting of child sexual abuse crimes committed before 1982 was only changed in South Australia as recently as 2003.

Widespread reluctance to acknowledge family and care-giver abuse has resulted in an almost exclusive focus on extra-familial abuse, coupled with 'stranger-danger' messages in our society.

### ***Perpetrator tactics***

Children are often taught quite deliberately by perpetrators to keep the abuse a secret. This can be achieved by threats, bribes, punishment, or blackmail. Several people in our *Respond SA* research (Breckenridge et al. forthcoming 2007) reported that perpetrators persuaded them that disclosure would lead to them being put in a foster home, or that their mother would be institutionalised. In a process sometimes called 'grooming', children's trust in the perpetrator may be gradually developed and they may be treated as someone special, by being given special treats or compliments. This can lead to a great deal of confusion in the child's mind about what constitutes abuse and who is responsible. They may be given the impression that they have consented or even that they have initiated the relationship.

A tactic that is frequently used by abusive fathers or stepfathers focuses on disrupting the child's relationship with the mother. It has been reported in several studies, (for example, Laing 1999 and Morris 2003), that a common tactic used by perpetrators is to create alienation in the mother-child relationship. This is achieved by telling the child that the mother is inadequate, unloving or in some way bad or fragile. The young person is therefore surrounded by contradictory messages, experiences and representations about what constitutes love, trust, care and family life. This confusion may also lead to children maintaining a lengthy silence about their childhood abuse.

## **2.3 Effects of child sexual abuse**

### **[Issue 3.2]**

The research literature is unequivocal in asserting that a significant proportion of people who are subjected to child sexual abuse will, as a result, experience short or long term social, emotional and psychological problems of a serious and disruptive nature.

Effects that have been identified include:

- harmful impact on the child's developing capacities for trust, intimacy and sexuality, all of which may manifest in various difficulties in adulthood (Mullen & Fleming 1998)
- symptoms of post traumatic stress disorder including hyper-alertness, dissociation, disconnection from everyday life, alongside feelings of guilt, responsibility and self-blame (Hayes and Tiggerman 1999).
- higher rates in adult life of depressive symptoms, anxiety disorders, substance abuse, somatic and eating disorders and self-harm, including suicide.<sup>5</sup> Creedy et al.(1998) argue that women who are victims of prolonged childhood sexual abuse involving penetration and physical and emotional abuse are more likely to develop major psychiatric distress. These survivors may use defence mechanisms to block out the past, and their distress may only come to the attention of health professionals at times of crisis.

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<sup>5</sup> Briere and Runtz (1988), Mullen, Martin, Anderson, Romans and Herbison 1993.

- impact on parenting ability, anxiety and hyper vigilance about their own children. Douglas (2000) reports that mothers with a history of child sexual assault were significantly more anxious about intimate aspects of parenting and reported significantly more overall stress as parents.
- a potential link between child sexual abuse, drug addiction and patterns of offending behaviour that lead to women being imprisoned. For example, Lawrie (2002), in researching the needs of Aboriginal women in prison, found that 70% of those interviewed (n=50) said they had been sexually assaulted as children and most had also suffered other types of childhood abuse. The Australian Senate Report on Australians who experienced institutional or out-of-home care as children – *Forgotten Australians* (2004) – claims that many care leavers (many of whom were abused in care) have turned to illegal practices such as prostitution, or more serious offences, which have resulted in them comprising a large percentage of the prison population.
- a relationship between childhood victimisation and subsequent victimisation in adulthood. A recent Australian Institute of Criminology report on women's experiences of male violence<sup>6</sup> found that the risk of sexual violence in adulthood doubles for women who were abused as a child (54% compared with 26%). This finding clearly has significant health and welfare implications for State and Territory governments, and indicates that child sexual abuse cannot be seen in isolation from other violence such as domestic violence.

This selected list of effects indicates that child sexual abuse has far reaching effects. It is not only a major public health issue, but one which impacts on many aspects of social and emotional wellbeing, including parenting and relationship capacities.

While child sexual abuse is destructive and can have ramifications that continue into adulthood, adults and children can and do move on from these experiences and can be assisted to do so. Just as the effects of abuse can be exacerbated by negative circumstances or events, they can also be assisted by positive relationships and appropriate therapeutic or other responses.

However, the under-reporting of child sexual abuse to health and welfare professionals suggests that many people who have been abused do not go on to receive appropriate help and support – if they receive any help or support at all. It is also common for adult 'survivors' to seek treatment from a medical practitioner or other therapeutic service for various psycho-social *symptoms* of abuse (for example, drug and alcohol misuse, depression, anxiety, sexual or relationship difficulties) without the underlying issue of childhood sexual abuse ever coming to light.

Key point	CISC Issue
<p><b>Understanding child sexual abuse and its effects</b></p> <p>It is well established that the prevalence of child sexual abuse (CSA) is unacceptably high and that perpetrators are frequently family members or trusted people known to the family or people in a care-giving role, as is the case for many children in State care. The sexual abuse of children in State care therefore cannot be considered in isolation from childhood sexual abuse more generally.</p> <p>An understanding of the incidence and dynamics of child sexual abuse is necessary in developing responses in relation to:</p> <ul style="list-style-type: none"> <li>- prevention</li> <li>- service responses to children and their families</li> <li>- service responses to adults who have been subjected to childhood sexual abuse</li> <li>- service responses to perpetrators.</li> </ul>	<p><b>[Issues 2.1, 2.2, 2.3]</b></p>

<sup>6</sup> Mouzos and Makkai (2004). This report was based on the analysis of the Australian component of the International violence against women survey (IVAWS). The full report is available on the AIC web site: <http://www.aic.gov.au/publications/rpp/56/index.html>



### 3. Disclosure and help seeking

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Disclosure cannot be adequately understood without an understanding of the dynamics of child sexual abuse. In particular it is important to recognise that abuse often occurs in a context of multiple abuses of power. A range of practices of power are often used by a perpetrator to impose secrecy about the abuse and isolate the child/survivor from the care and support of significant others, usually their mothers (Humphreys 1995). To achieve secrecy, children and young people are threatened, bribed or coerced into not telling anyone for fear of reprisal from the perpetrator towards themselves or significant others. Equally, the threat of family dissolution in intra-familial abuse and the associated possibility of out-of-home care may force the child to keep the sexual abuse a secret.

These strategies and resultant dynamics frequently prohibit or constrain disclosure and they are often poorly understood. It is also important to recognise that disclosure is best understood as a process rather than a static event. During the process children and even adult survivors may not feel able to disclose at all or only partially disclose over a period of time. In some cases, children may recant disclosures. Children may also disclose non verbally (for example, through withdrawal, rebelliousness, running away) and these behaviours may not be identified as disclosure.

#### 3.1 Disclosure and help seeking by children

##### [Issues 2, 4, 5 and 22]

For a range of systemic and logistical reasons, records of the numbers of children who disclose sexual abuse are patchy and almost certainly underestimations. Those who do disclose frequently tell family or friends. There is a low rate of disclosure to professionals or to those who may keep official statistics. Further, there is limited Australian research data on this topic.

However, we do know that children, in Australia and elsewhere, frequently do *not* disclose their experiences of sexual abuse. Alaggia (2004) reported that most studies of disclosure found that between 30% and 80% of victims purposefully do not disclose these experiences before adulthood.

The incidence of disclosure among special population groups may be even lower than these figures. For example, reports to the police about child sexual abuse in Indigenous Australian communities, can be limited because of the legacy of both colonisation and past policies of removing Indigenous children. In addition, fears are held that an offender, if convicted, may be the next 'death in custody' (Greer and Breckenridge 1992). One of our counsellors expressed her concerns about this:

*There is an additional pressure on Indigenous and culturally and linguistically diverse families to keep quiet. They don't want to fracture communities. Speaking out can divide a community.*

The research also indicates that where children *do* disclose sexual abuse, as children, such disclosure does not automatically result in professional help. For example, it is estimated that between one third and a half of children referred to counselling fail to attend the first appointment (Breckenridge et al. 2007 forthcoming). There is evidence that victims of intra-familial abuse may be especially reluctant to seek professional help. Breckenridge (2002) suggests that the idea of helpfulness is frequently lost post-disclosure of child sexual abuse in favour of a legal response which tends to dominate and shape all other professional work. In this context therapeutic responses to the needs of the child are often made secondarily to the legal response. This is also the situation for adults who disclose childhood sexual abuse where a prosecution is in progress.

From the research which RA (SA) commissioned on disclosure and help seeking, 60% of our adult participants (who had all been subjected to childhood sexual abuse) said they had not attempted to tell anyone of the abuse in their childhood or teenage years. The minority who did disclose mostly told friends. Other confidantes were mothers, aunts, and other family members.

In speaking about what had inhibited disclosure, our participants mentioned:

- fear of reprisals by the perpetrator
- fear of how it would reflect on themselves
- fear of being removed from the family
- low self esteem and lack of confidence
- fear of not being believed
- a sense of shame and self blame
- not knowing that it was abuse
- strongly held beliefs about the privacy of 'family business'
- not wishing to hurt others (e.g. a mother or in some cases the perpetrator himself).

The following two quotes from *Respond* clients indicate how complex the issue of disclosure can be for children especially when childhood sexual abuse is surrounded by secrecy and not named as abuse.

*I knew what was happening was wrong. It was made a secret by the perpetrator. The family dynamics were such that I couldn't speak about it. I didn't have the language. I didn't see it as an issue. Sex was a taboo subject in the 60s, so it was something that you were taught not to talk about.*

*It wasn't named as abuse at the time...I wish I'd known then as a child that it was abuse and I could have started working on it – the damage it caused...it would have answered lots of questions – my behaviour and other effects.*

There is a need for wide community awareness of child sexual abuse and acceptance that it is a whole of community responsibility. Such a shift in understanding and sense of responsibility must necessarily be underpinned by comprehensive and extensive community education. There are many compelling reasons to undertake this initiative. These include that:

- The responses which children receive in relation to disclosure are likely either to facilitate recovery from the trauma or further perpetuate or intensify it.
- The quality of response that is given in response to disclosure strongly influences how the child will deal with the experience, both in childhood and adulthood.

We know from Relationships Australia (SA)'s research on help seeking, that many adults did not disclose as children, for a range of reasons based in fear and anxiety or, as the CISC Issues document identifies, due to "the absence of anyone in the child's life whom the child trusted and to whom they felt disclosure could be made with safety and protection". **[Issue 22: 'Disclosure and Advocacy']**.

It is also true that the silence surrounding the issue of childhood sexual abuse closed doors of opportunity to speak. Adult participants in RA (SA)'s research recounted occasions when they had indicated their distress, with such actions as running away. Invariably however child sexual abuse was never identified or mentioned as a factor in such behaviour.

It is important that child sexual abuse is not regarded in the community as solely being the concern of experts. We have seen the development of community awareness and responsibility regarding domestic violence and it is important that this is matched by similar developments in the understanding of child sexual abuse.

The kinds of messages that are important to convey to the community are that:

- Child sexual abuse is a crime, and that if it is happening within families or family social networks this does not mean that it is a private matter
- The child is never to blame
- Good quality simple responses can make an enormous difference to the child
- Good community awareness is a significant part of an overall system of social support
- Children can be 're-victimised' when their problems are ignored or minimised

The research evidence detailed above sheds some light on the question posed in **[Issue 4.10: 'What factors have contributed to the low report rate?']**.

Relationships Australia (SA) research data and other studies indicate that children's needs when disclosing abuse are complex and often ambivalent. While they wanted the abuse to stop, they didn't necessarily want to lose other aspects of the relationship with the perpetrator.

Counsellors spoke frequently of the importance of family to their clients. This operated on a number of levels. One level was the altruistic concern about the consequences of their disclosure of a family member's abuse, in particular the potential to hurt the non-offending parent and/or break up the family. Another level of concern, especially for children, focussed on their own loss of significant family relationships. A *Respond SA* counsellor expressed it this way:

*My sense is what children want most is for the abuse to stop. Most of the people I meet with would say they wanted the good relationship with the other person, but they didn't want the abuse.*

*And so for a child to disclose they also lose all this other stuff. They lose what they understand about family, there is the potential to lose what our culture valorises in relation to family – you know mother, child, father, all in the same house.*

### **Responses to childhood disclosure**

The research which RA (SA) commissioned (Breckenridge et al 2007, forthcoming) revealed that most people interviewed spoke of their childhood disclosure as having negative repercussions.

It emerged that a very high price can be paid by children who disclose to people who are threatened by it, who use it as an opportunity for further abuse, or who are simply ill-equipped to deal with it. Several people reported extremely negative experiences following disclosure at school or church.

A common scenario reported by the adult survivors in our research was that their childhood disclosures were met with a lack of response. The issue was (ostensibly) ignored – 'a blind eye was turned'. There were several examples in our research sample where no action was taken following reports to child protection agencies and a hospital. Several people spoke of the 'matter never being spoken of again'. RA (SA) knows from its work in domestic violence, that when victims disclose and nothing happens in response, then they are at greater risk of being abused again. A similar pattern is likely with child sexual abuse.

Several children in our research met with judgemental attitudes when they disclosed. Some confidantes seemed to suggest that the abuse was the child's fault, i.e. that they had invited it or had been careless in allowing themselves to get into situations of risk. A number of people spoke of being made to feel ashamed, guilty, dirty, or responsible.

Many childhood disclosures met with shock or disbelief. In a number of cases it was apparent that the confidante did not want to believe. In the few cases where police action followed disclosure, a child could still feel that the actual experience of abuse was being denied.

Overall it was apparent that disclosure (or non disclosure) in childhood generally put victims 'between a rock and a hard place'. It was difficult to tell. It was difficult not to tell. As one woman expressed the dilemma: 'I wanted someone to know, but I didn't want to be judged'.

However, it should be noted that the adults in Relationship's Australia's SA's research were talking about childhood disclosures in the past, in some cases going back decades. Have responses changed? Are things different now that we have mandatory child protection, for example? It is reasonable to assume that the SA Government's response to the issue of childhood sexual abuse has in itself communicated to the public that this is a serious issue, and this may have improved the context for reporting. In addition, there are now other services (e.g. the Kids Helpline) that did not exist in the past.

Nonetheless, while all of these initiatives establish a different context than the one which existed in the past for current adults, we suggest that it is still likely that there are many children who receive inappropriate responses, both from family members, 'lay' confidantes and from frontline workers to whom the child may disclose. Limitations in the ability to respond is supported by the national interviews Relationships Australia (SA) conducted with nine different frontline worker groups about responding to children living with domestic violence. These indicated that frontline workers have not received training on these areas, other than basic mandatory reporting training, and were unclear about their responsibilities and the boundaries of their role. Some simply referred the matter onto others without getting involved. Others became over-involved and overstepped the bounds of their role. This raises the question of whether frontline workers (e.g. teachers, child care workers, GPs) are clear about both the importance of their role beyond simply mandatory reporting, and at the same time the limits of their role in relation to counselling and other more specialist interventions. Once again this points to the need for comprehensive training around childhood sexual abuse for a whole range of workers.

Key point	CISC Issue
<p><b>Helping children to understand and report child sexual abuse</b></p> <p>As outlined in this section, there are very significant factors which children must overcome in order to report sexual abuse and these issues should not be underestimated.</p> <p>Children do need to be informed about sexual abuse and their right to safety. Age appropriate books and other resources in this area already exist and strategies to inform children are required.</p> <p>However it is also important to recognise that perpetrators use tactics which make it difficult for children to make reports. In addition to threats and intimidation, children who are vulnerable and/or isolated are often deliberately selected for abuse.</p> <p>Furthermore perpetrators report deliberately socially isolating the child from other adults. Finally we must recognise the use of tactics by perpetrators to ensure that they are respected in their community which in turn is used to discredit any report by a child.</p> <p>Children are clearly lacking power in these situations and children in State care will be even more powerless given the additional trauma they will have faced, likely dislocation and possible social isolation. <b>Whilst we must ensure that children are informed of abuse and their rights to safety the onus of responsibility cannot be placed on the child in this respect.</b></p> <p>Children's disclosures must be facilitated in the context of widespread community awareness and understanding of child sexual abuse to ensure improved responses by family and friends.</p> <p>In addition it is crucial that frontline worker training is extended to ensure that people who children come into contact with are well informed and alert to child sexual abuse and able to respond.</p> <p>Initiatives which increase children's access to adults in their community are supported.</p> <p>Children in State care need to be able to confide in a suitable person they can trust, and we support the suggestion of a special independent facility for this purpose.</p>	<p><b>[Issue 2.6]</b></p> <p><b>[Issue 3.2]. [Issue 25]</b></p> <p><b>[Issue 4.10]</b></p> <p><b>[Issue 4.1]</b></p> <p><b>[Issue 22]</b></p>

## Professional development training

RA (SA) believes that all training should be integrated within a broad workforce development initiative which sustains and enhances the skills and knowledge of organisations and workers to respond effectively to children and adults who have experienced childhood sexual abuse, and/or their families, and develops appropriate interpersonal violence prevention strategies.

We believe that specialists working in the field of child sexual abuse should have input to the design and delivery of professional awareness and other relevant in-service training for the frontline workers, carers, and other professionals.

Front line worker education programs should cover the following:

- what constitutes child sexual abuse
- that it is a crime and a breach of human rights
- its prevalence in family and other contexts
- statistics on different perpetrator groups
- the tactics that perpetrators use to secure silence
- the abuse of power inherent in child sexual abuse
- that adult perpetrators are solely responsible for the abuse
- that children, by definition, are incapable of giving informed consent to sexual abuse
- that children should be able to tell trusted adults about any abuse they are subjected to
- what others can do if they suspect that a child is at risk (e.g. reporting to police, Families SA)
- that child sexual abuse is a community issue requiring vigilance and appropriate responses
- how to respond to a disclosure by a family member, friend or as a front line worker.
- understanding the dynamics involved in disclosure (e.g. a child disclosing has usually identified some quality in the confidante that they can trust – people who have been abused are often very attuned to 'reading' people's likely responses
- understanding needs beyond mandatory reporting protocols and requirements (i.e. needs of the person or child who has been subjected to CSA).

Education should be incorporated into relevant tertiary courses. In particular there should be units/modules on child abuse, including child sexual abuse, in the training provided to all school teachers, kindergarten and pre-school teachers, child care workers, social workers, allied health workers, the medical and legal professions, youth and community workers and the clergy.

It should be recognised however that many professional training courses suffer from insufficient time to incorporate all important issues. Further that for many workers their learning will most effectively occur once they are in their workplace confronting the issues. Consequently effective training must be available to workers once they are performing their professional roles.

It is crucial that workforce development should include training and information about these issues for all those in relevant work contexts whose pre-service training did not include it, and those whose knowledge needs refreshing or updating. Others in positions of responsibility involving children, such as members of school, church or sporting or recreational club committees, should also be provided with training in these issues.

[Issue 2.4,  
2.7 and 3.3]

<p>In addition to in-service training by employers, the Interagency Training Calendar on “Skilling a Workforce to Respond to Violence &amp; Abuse” is an important way of enabling access to training for different worker groups.</p> <p>RA (SA)’s national resource and allied training program, <i>Point of Contact: Responding to Children and Domestic Violence</i>, is a model that could be emulated. This program was targeted at frontline workers from nine workplace groups whose work involved responding appropriately to children living with domestic violence. A similar resource could be developed for frontline workers likely to encounter children who are sexually abused.</p> <p>Families SA and non government agencies involved in child care and protection should publish information and provide services which may assist in the correct interpretation of circumstances which could be indicative of child sexual abuse. Agencies such as <i>Respond SA</i> have a particular responsibility to disseminate information (via short courses, workforce development, fact sheets, brochures and website content) which will assist adult survivors of childhood sexual abuse.</p> <p>The State Government is commended for introducing in government schools the SMART (Strategies for Managing Abuse Related Trauma) program for the training of teachers and other school personnel, about the signs of child sexual abuse, and its physical, psychological, and emotional impact and other effects.</p> <p><b>Mandatory reporting</b></p> <p>RA (SA) supports the continuation of mandatory reporting for the following reasons:</p> <ul style="list-style-type: none"> <li>• It is important to communicate an unequivocal message in our community and to the children themselves that child sexual abuse is illegal and that action will be taken to ensure that it ceases.</li> <li>• It is quite clear that there is widespread ignorance about child sexual abuse and that responses are often either lacking or inappropriate. We suggest therefore that relying on a community response alone (including a response by individual workers) will not ensure either the safety of the child nor assistance for them to cope with the situation and the effects of abuse.</li> <li>• It is the responsibility of the State to ensure that children are safe and thus reports to State authorities should be made.</li> </ul> <p>Issues confronting front line workers on how to make a report and at the same time sustain a relationship with the child (and family) are difficult and need to be addressed through more extensive training and wider community support services and strategies.</p> <p>Additional resources for specialist assessment teams and treatment services are crucial. Alternatives to removal of the child from the family are all supported as initiatives to ensure that a wider range of responses to a report are available.</p>	<p><b>[Issue 2.5]</b></p> <p><b>[Issue 3.4]</b></p> <p><b>[Issue 4.2]</b></p> <p><b>[Issues 4.3, 4.4]</b></p> <p><b>[Issues 5 and 7.1]</b></p>
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### 3.2 Disclosure and help seeking by adults

For adults, the decision to disclose is not necessarily linked to the desire to report or have any formal action taken. *Respond SA* research (widely reflected in research literature generally) reveals that disclosure for adults is an extremely difficult, complex and painful process that does not begin or end with a single disclosure about the sexual abuse they were subjected to in childhood. Commonly, the abuse has been surrounded by silence, anxiety, confusion, fear and shame.

In our own research and in other major studies,<sup>7</sup> adult survivors attributed not disclosing childhood sexual abuse to not knowing that services existed or not feeling safe enough to disclose the actual cause of their distress.

Fleming (1997) found that less than 10% of child sexual abuse incidents were ever reported to the police or a helping agency. She concludes in her study of 710 women, that the high rates of child sexual abuse experienced, and the low rates of reporting of the abuse indicates a need for GPs and other health care workers to become aware of the prevalence of the experience in women in the general population. Similarly, Smith et al (2000) found that in a sample of 288 adult survivors only 12% stated that their abuse had been reported to authorities at some point.

The research literature is consistent in indicating that the majority of people who have been sexually abused as children, do not disclose until adulthood (if they disclose at all).<sup>8</sup> In addition, most adults who do disclose do so, in the first instance, to a friend or trusted person they know.

Adult survivors often seek help from generic organisations and choose not to, or cannot, always disclose their past childhood abuse. Very often they present to services with a range of related critical health and welfare issues. Holden (2002) highlights that many survivors contact general practitioners, psychiatrists and other health and welfare professionals, often presenting with depression, anxiety, drug and alcohol misuse and other related conditions.

Further, survivors often re-present repeatedly to generalist services for the same or substituted symptoms because the underlying issue of trauma has not been addressed.<sup>9</sup> This finding is supported by Jonzon and Lindblad (2004) who argue that to seek support through disclosing, a victim of childhood sexual abuse must first challenge the social reluctance to acknowledge CSA and respond supportively.

Importantly, apart from designated services, survivors of CSA are frequently seen by workers who are not specialised or trained to deal with the direct effects of childhood sexual abuse, and any disclosures may be minimised or ignored in favour of treating 'symptoms' (Stojadinovic 2003). These same workers may not receive adequate information about CSA, supervision, peer support or debriefing (Holden 2002).

This finding is affirmed in a study by Crisma et al. (2004) which reveals that professional responses to disclosures of CSA were much less supportive than family responses, and that some families were very helpful in stopping the abuse. They also found that professionals didn't ask about the possibility that child/adolescent pregnancy or anorexia, for example, could have been the result of abuse. Participants also reported a lack of awareness of available protective services and a mistrust of adults and professionals more generally.

<sup>7</sup> For example, Women's Health Statewide 1994; *Australian Bureau of Statistics* 1996; and King 1998

<sup>8</sup> For example, Lamb and Edgar-Smith (1994) De Visser et al. (2003).

<sup>9</sup> Herman 1992; King 1998; and Breckenridge 1999.

The most common themes raised by survivors seeking assistance in generalist contexts are:

- the need to feel safe and have some sense of control during an appointment or procedure
- issues associated with disclosure of the abuse.
- a desire for practitioners and referral specialists to understand the issues involved in child sexual abuse and to work with survivors in sharing information and control (Schachter et al. 2004).

There is considerable evidence to indicate that specialist responses to adult survivors of childhood sexual abuse are likely to be far more effective than generalist services that are established to respond to a whole range of psychosocial or mental health issues.

However, there is also an overwhelming call from researchers and practitioners in the field for generalist health and therapeutic professionals to increase their capacity to respond to adult survivors of childhood sexual abuse. Capacity building is not only the responsibility of individual professionals and agencies but also needs to be addressed by tertiary institutions and sector development strategies. Specialist services could potentially have a greater involvement in capacity building in generalist services than has previously been the case.

### ***What adult clients say about generalist services***

Clients of *Respond SA* have described in research interviews, the multiple effects of having been abused. These have included:

- Lack of trust
- Fear, shame, self loathing
- Confusion about love and sexuality
- Difficulties with intimate relationships
- Living with fractured family relationships, where some family members know and some do not (or some believe and some do not)
- Living for many years in silence about the abuse
- Pretending that all is well, when in fact, they are feeling desperate.

Not surprisingly, given these levels of complexity, survivors are not likely to disclose during a short appointment or if they have not established a relationship of trust with the practitioner, or if they fear that person may not understand the issues. Their experiences of help seeking in generalist contexts reveal that such services are not trained or set up to identify or deal effectively with the multiple issues surrounding CSA. As one client explained it:

*Part of holding onto memories and not speaking about them, and retaining the suffering is about a 'heroic conscience' and not wanting others to be hurt. You don't want the suffering but you don't know where to go with it.*

Several people feared that disclosure, even to a professional, would result in another form of power abuse. One expressed a fear of 'having to pretend to feel better' even though she may not, and that there would not be enough sessions available to help her work through it. Some women reported the experience of feeling that their husbands and their GPs viewed them as 'the problem' (because they were not sexually responsive). This was just one example of compounding oppressions that were revealed as a consequence of CSA.

Other clients have felt that they could be judged and blamed for the abuse. Many clients have experienced the stigma attached to being abused. It is evident that a number of hurtful, stigmatising stereotypes still have currency. One concerned the belief that the child or teenager had some responsibility for the abuse – 'If you're in it, you did it', as one woman put it.

Another mentioned the persistent belief that 'little girls play up to it'. A counsellor in the *Respond SA* service explained to researchers that alongside an individual's experience of abuse, there are also many social messages that represent girls and women as 'asking for it' or as in some way responsible for male sexual behaviour. All of these factors contribute to silencing the victim. This is of particular concern if people who are looked to for support and assistance convey such damaging messages and stereotypes.

Conversely, when a professional response has been experienced by a survivor as helpful, the therapeutic benefit was extremely high, even if the interaction was only brief. As one participant in the *Respond* research on help seeking explained:

*A GP's use of logical cause-effect propositions – what she described as a 'scientific approach – was extremely useful. An example was, 'I have low self esteem because it was taken away from me'.*

Consistent with the research literature, clients identified help given prior to their accessing a designated, specialised service, as focusing on symptoms rather than underlying causes. Our own early data collection (2004/2005) reveals that although 76% of *Respond SA* clients had previously sought counselling, 61% of these clients had never received any counselling for the CSA that they had been subjected to.

There is a clear need for capacity building around CSA in generic counselling services and in frontline health and community services delivery. From a consumer point of view, being believed, understood and not blamed or judged are identified as being of highest priority. It is obviously also important however, for a service deliverer to have some skills (and/or referral knowledge) beyond an empathetic attitude. There are also some specific issues that need to be handled with sensitivity and awareness of the potential broad-ranging CSA effects which go well beyond health consequences into the whole area of relationships and parenting. These effects may include difficulties with intimacy and sexuality, ambivalent and distressed responses to pregnancy and childbirth, difficulty with intimate aspects of infant care, and lack of confidence with parenting.

There are also particular issues for men who have been sexually abused that require awareness and information. One example is the personal confusion that can occur around the possibility of being gay and the widespread homophobia that exists. This is a very difficult topic for men to discuss and many feel that disclosure of CSA will be met with an assumption that they must be gay. For this reason many men feel unable to disclose sexual abuse or to discuss their childhood sexual experiences and any ambivalence they may have felt about these. This demonstrates again that many of the problems and difficulties that survivors face are grounded in social (and professional) misinformation and ignorance.

### ***Views on specialist services, in particular Respond SA***

South Australian research has repeatedly highlighted the need for a specialist service for adult victims/survivors of childhood sexual assault (both men and women). In 1994 a report by Women's Health Statewide documented this need.<sup>10</sup> This point had earlier been made in a report by Carmody (1991)<sup>11</sup> It continued to be a recommendation in another WHS report of 2002 – *It's still not my shame*. Similarly, the 2005 Evaluation of *Respond SA* (Breckenridge et al. 2005) reflected the importance of a specialist service and it also emerged as a theme in RA (SA)'s recent research on disclosure and help seeking (Breckenridge et al. 2007 forthcoming).

<sup>10</sup> Women's Health Statewide (1994) *It's not my shame*.

<sup>11</sup> <http://www.aifs.gov.au/acssa/pubs/wrap/w1.html#six>

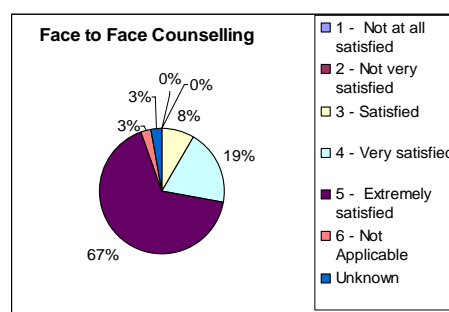
Overwhelmingly, client feedback (both in evaluation of services and in specific research about help seeking) reports a consumer preference for a designated service in relation to adults who have been subjected to CSA. The reasons given for this are consistent and twofold. The first reason is that clients (both men and women) do not have to struggle to negotiate how to raise, explain or discuss CSA. The fact of accessing the service, by definition, means that the phenomenon of CSA is understood by the service and professional staff.

The second reason is that the counsellors who clients see are specialists in the area. Consumers are often highly skilled at 'reading' the nuances of whether or not the person they are consulting understands the issues. Consistently, clients of *Respond SA* reported feeling confident and safe.<sup>12</sup> In addition, administrative and support staff are trained to offer assistance and answer queries in a way that is appropriate to the context.

In the Evaluation of the *Respond SA* counselling service, the particular features of the service highlighted by clients, were that:

- Counsellors worked with them in particular ways on the life issues that they had difficulty with. Clients felt that they were central in defining and scoping the therapeutic goals.
- Their own needs were addressed with flexibility relating to the number of appointments needed and the most suitable strategies to include, e.g. moving to a group counselling context at an appropriate time.
- 'Their' counsellor had expertise and understanding of the issues they presented.
- They were believed, not judged, and were supported to explore all relevant issues.
- They understood (some for the first time) that a crime had been committed against them and that they were powerless to have stopped it at the time.
- A huge burden had been lifted in being able to 'work through' the multiple layers of meaning and experience that they live with.
- They had new ways of dealing with issues, for example how to manage some difficult family relationships.
- They had a more optimistic view of themselves and their future.
- They were able to speak out (in many cases for the first time).

A snapshot of client satisfaction with *Respond SA* was published in 2006, indicating outstandingly high levels of satisfaction with all its services. The diagram which follows illustrates satisfaction with face to face counselling.



In the Evaluation of *Respond SA* (Breckenridge et al. 2005) many stakeholders (service providers in the sector) saw an ideal model of service delivery as being one that could wrap training and community development around service delivery (p.40). There was also a strong argument made that training had to be informed by clinical expertise, and that the organisation needed to collaborate with other agencies in the sector.

<sup>12</sup> Breckenridge et al. 2006, *Respond SA: Service Usage & Client Satisfaction*, July 2004 – November 2005

The establishment of *Respond SA* has clearly provided a vital service for the South Australian community and is one for which there is a high level of demand for all components of its services. It is recommended that this service be funded on an ongoing basis.

Key point	CISC Issue
<p><b>Helping adults to understand and report childhood sexual abuse</b></p> <p>There is a high incidence of childhood sexual abuse in our society and thus a large number of adults in our community who have been subjected to sexual abuse in their childhood.</p> <p>Research clearly indicates that childhood sexual abuse does have ongoing effects on many adults and these effects have been outlined earlier in this submission.</p> <p><i>Respond SA</i> research and other international studies indicate that there are significant problems which will continue to need to be addressed in relation to responses to disclosure by adults and the assistance provided by generalist services.</p>	<p><b>Inquiry Terms of Reference (2d)</b></p> <p><b>[Issue 33]</b></p>
<p><b>Community and professional education</b></p> <p>Continued and expanded community education is required which informs people about the effects of childhood sexual abuse on adults and how to respond and support a family member or friend who makes a disclosure. Adults cannot be simply told to “get over it.”</p> <p>Continued and expanded training for frontline workers is required. In addition to the items outlined earlier, frontline worker education programs focused on working with adults should cover the following:</p> <ul style="list-style-type: none"> <li>• Social and legal definitions of CSA</li> <li>• Characteristics and dynamics of abuse</li> <li>• Statistics regarding the incidence and prevalence of CSA</li> <li>• Common beliefs re abuse e.g. who the perpetrators are, who the victims are, why child abuse occurs</li> <li>• Impact and effects of CSA</li> <li>• Frameworks, therapeutic models and approaches that inform practice</li> <li>• Responding to disclosures of abuse</li> <li>• Practice and Professional issues</li> <li>• Vicarious trauma or the impact of the work on the frontline worker.</li> </ul> <p>Continued and expanded training is required for particular groups of workers (e.g. prison workers, GPs and drug and alcohol services workers) who need to have a high index of awareness about the correlation between child sexual abuse and subsequent problems such as drug and alcohol misuse and the causal factors leading to illegal practices and imprisonment. In particular, it is important that such practitioners be aware that the ‘presenting symptoms’ (e.g. depression, anxiety, substance misuse) may have their origins in child sexual abuse and this may not necessarily be revealed, at least initially.</p> <p>To ensure an integrated range of services and ensure that training provision is grounded in practice experience, <i>Respond SA</i> has been funded to have a major role in the development and provision of training on issues relating to adult survivors of childhood sexual abuse. Consequently the <i>Respond SA</i> team includes a senior training position, and practitioners who work with clients are involved in training provision.</p>	<p><b>[Issue 37]</b></p>

Thus, in addition to the Interagency Training Calendar on “Skilling a Workforce to Respond to Violence & Abuse,” *Respond SA* has an annual training calendar and provides training to specific groups of workers, (see section 1.2e) The annual *Respond SA* training (attached) includes, for example, workshops on:

- Responding to adults subjected to childhood sexual abuse
- Foundation knowledge and practice
- Responding to adults subjected to CSA for workers in Institutional care settings.
- Narrative approaches to working with adults subjected to CSA.

In addition Women’s Health Statewide and *Respond SA* provide a monthly “Friday Forum” on issues related to violence and abuse.

All of the above training initiatives are available to both front line and professional workers and provide a comprehensive range of training.

### **Specialist services**

There is a clearly demonstrated need for specialist services to respond to the needs of adults who have been sexually abused as children, including adults who have been sexually abused whilst in State care.

The evaluation of *Respond SA*, client surveys, research reports and usage patterns of the service clearly indicate the need for ongoing service funding. The existence of *Respond SA* has ensured the provision of an integrated range of services to:

- Provide community education
- Develop community resources
- Develop and provide both frontline and specialist worker training programs
- Provide counselling, group work and other services to assist adults who have been subjected to childhood sexual abuse.
- Provide policy advice.
- Undertake research.

**[Issue 32, 33  
and 35]**

## 4. Out of home care

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This section examines the particular issues relating to children in State care and the needs of young adults post care [**Issue 32**]. The following points are highlighted:

- Any child placed in out of (original) home care is likely to suffer trauma
- The events precipitating placement are usually, by definition, traumatic and the processes involved in alternative placement may compound this trauma
- Foster carers require training and support to understand trauma and its potential behavioural manifestations and be able to respond appropriately
- A child who is placed in care needs to have a consistent and reliable 'protective cocoon' provided by a range of appropriately skilled interested parties
- Stopping child sexual abuse is a necessary but not sufficient response to meeting duty of care obligations
- Adults need to be committed to understanding and learning from the child about the child's needs, experiences, priorities and preferences, and need to work collaboratively to support the child in positive ways
- The child who is placed in care needs ongoing relationships with skilled, empathic adults who are consistent, and readily available
- Young people need continuing support after care to assist in establishing positive directions in adulthood. Services should include advocacy and assistance in accessing employment and educational opportunities, addressing health and housing needs, counselling services, and support for needs arising in relation to meeting family and friends.

It is important to recognise that any child or adolescent, who is placed in out of (original) home care, is likely to have experienced multiple layers of trauma and difficulties. They may also blame themselves for having 'caused' the circumstances that they find themselves in and may then experience a range of problems upon leaving care.

The *Forgotten Australians Report* (2004) describes the long-term impacts of a childhood spent in institutional care as 'complex and varied'.

*In some cases, children were already suffering from life in a dysfunctional family. However, the outcomes for those who have left care have, in the main, often been significantly negative and destructive. (p.145).*

The report identifies the legacies of institutional care as encompassing low self esteem, depression, fear and distrust, anger, shame, guilt, and social anxieties and phobias. It categorises the negative consequences as impacting on quality of life, relationships, parenting skills, health, educational attainment, employment prospects, housing opportunities, and anti-social or criminal behaviour. It identifies profound costs to individuals, families and society (Chapter 6).

The Queensland Aftercare Resource Centre has identified a number of possible effects that institutionalisation as a child may have. Institutionalised people may have a whole range of feelings including feeling abandoned, unloved, isolated, suspicious, and worthless. They identify possible primary effects as:

- Abandonment
- Separation
- Segregation
- Isolation
- Lack of trust.

Secondary effects can include:

- Literacy and numeracy problems
- Unemployment
- Poverty
- Poor living conditions
- Poor health
- Relationship and Parenting Problems
- Poor coping skills
- Substance Abuse.<sup>13</sup>

In addition to the traumatic experiences that are likely to have occurred **before** children are placed in alternative care (institutional or foster care), the processes, events and transitions involved during the placements are often, in themselves, traumatic. Trauma is then compounded if the alternative care context is in itself abusive. Children who live or have lived in these levels of crisis, require particular support if they are to emerge strongly from it.

Supporting a child who has been traumatised involves creating a 'protective cocoon' that establishes trust and predictability (McIntosh & Deacon-Wood, 2004). It also requires adults who are in ongoing relation to the child to pay serious attention to the individual child's needs. Paying appropriate attention requires particular qualities and skills, and a commitment to finding ways of learning about that child. These skills can be basic, such as the ability to listen non-judgementally. More nuanced and sophisticated skills will also be needed to notice (and act upon) the preferences and priorities of a child, as well as the subtle changes and developments that occur over time.

For children and adolescents in institutional or foster care, the origins of their trauma may not be singular and may not be at all obvious. It may just feel for them as if their whole life is always highly stressful. Children and young people in these situations often then find themselves in situations where things trigger reactions that often feel out of control or intense. Children and young people often report that they 'don't really know themselves' or 'don't feel normal' when this happens.

As well as expressing confusion and a lack of trust, a child in institutional or foster care may also demonstrate unusual skills and abilities that are not expected in children of their age. These skills can arise from having lived in complex situations. The ingenuity and intelligence of individual children can result in them developing ways of understanding or ways of doing things that are surprising. These abilities need to be appreciated and noticed just as much as the trauma reactions and difficulties. Part of showing interest in the individual child is the recognition of the skills and aptitude they have in their daily life.

Helping children to develop ways of expressing responses to their environment involves nurturing and developing communication possibilities. This can be through play or through conversation with older children. The silence and confusion that surround experiences of trauma, for children who have not had reliable and constant adults in their lives, is one of the ways in which the original experiences of trauma become compounded.

Finding communication options that are respectful and not overwhelming, which allow children in care to describe and express their reactions to their experiences, is not a simple task. We would not encourage anyone to *make* children talk about their trauma. On the contrary, we need interested parties to recognise that trauma has occurred for children in care and to let the details of the trauma emerge as the relationship between adult and child develops. As a respectful relationship develops, these children are likely to take the opportunity to discuss and reflect on their experiences because it is through such processes that children can recover and learn that their situation has changed.

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<sup>13</sup> Aftercare Resource Centre (ARC) Relationships Australia, Queensland (2006) *Working With People Who Were Institutionalised As Children*, PPT Presentation.

It therefore becomes very important to assist children in care to make sense of their lives for themselves and reflect on the ways in which they have both changed or stayed the same. This is not a quick process or something that can be achieved from one conversation or one set of experiences. It is not possible to achieve this quality of interaction outcome through assessment or legal processes alone.

It is imperative that the child is properly supported with mental health services and by carers who are skilled in responding effectively to children who may be experiencing trauma. It is important that these carers have information about the child's previous experiences so that they can take these needs into account during care. However, this is not a simple matter. Apart from questions of confidentiality, there are issues such as:

- What training, information, qualities and support do Foster and Residential Carers need to 'work with' information that they receive?
- How would information be conveyed?
- Who would define what constitutes 'relevant information' for these Carers to have?
- Would the child have any voice during such a process?
- What measures would need to be in place to prevent a child being viewed (or defined) by specific events in their life story.

Relationships Australia (SA) argues throughout this submission that, although the specific issue of child sexual abuse requires an effective and immediate response, it is not necessarily helpful to focus attention **only** on this single issue. Put another way, it is not safe to assume that having identified and stopped sexual abuse from occurring, that duty of care has been achieved – stopping the abuse is a necessary but not sufficient part of a broader effective response for a child's overall safety in alternative care. Children need to be supported by a range of skilled people (all operating within clear role boundaries) who can respond to complex and developing needs –emotionally, socially, physically and spiritually, as appropriate.

The work of the current RINC program signals some useful directions in relating to individual children's needs and working collaboratively with other interested parties towards good outcomes for individual young people. It has been an encouraging development for RA (SA) to have been involved with developing and delivering customised training for foster carers in this program.

There are inherent difficulties in recruiting and training foster carers to work in this area. It is highly challenging work and potentially disruptive to family life. During RA (SA)'s pre-training consultation with carers who undertake this work, a common theme was raised that the mental health problems of many of these young people are quite evident. And there was consistent agreement that their needs are often complex.

At the same time, there were also reports of great progress being made if the young person began to feel safe and involved in their new context. Being listened to non-judgementally and with respect seemed to be key features of positive progress.

Relationships Australia (SA), supports the concept of after care support being available free of charge to young people leaving care, who have experienced childhood sexual abuse. The challenges involved in emerging adulthood are met most successfully for those young people who have supportive people assisting them as inevitable needs arise. These needs include employment, education programs, housing, counselling, advocacy, and support with issues such as meeting up with family and friends with whom they may have lost touch. The Aftercare Resource Centre Support Services of Queensland and New South Wales are examples of this approach.

Key point	CISC Issue
<p><b>Out of home care</b></p> <p>RA (SA) strongly supports the idea that the safety and wellbeing of the child must be the first priority in any response or intervention. At the same time we acknowledge that removing a child into alternative care as a legal response to child sexual abuse, can cause additional trauma and dislocation in a child's life.</p> <p>We suggest that:</p> <ul style="list-style-type: none"> <li>• Any child placed in out of (original) home care is likely to suffer trauma</li> <li>• The events precipitating placement are usually, by definition, traumatic and the processes involved in alternative placement may compound this trauma</li> <li>• Carers need to understand trauma and its potential behavioural manifestations and be able to respond appropriately</li> <li>• A child who is placed in care needs to have a consistent and reliable 'protective cocoon' provided by a range of appropriately skilled interested parties</li> <li>• Stopping child sexual abuse is a necessary but not sufficient response to meeting duty of care obligations</li> <li>• Adults need to be committed to understanding and learning from the child about the child's needs, experiences, priorities and preferences, and need to work collaboratively to support the child in positive ways</li> <li>• The child who is placed in care needs ongoing relationships with skilled, empathic adults who are consistent, and readily available</li> <li>• Young people need continuing support after care to assist in establishing positive directions in adulthood. Services should include advocacy and assistance in accessing employment and educational opportunities, addressing health and housing needs, counselling services, and support for needs arising in relation to meeting family and friends.</li> </ul> <p>In relation to foster care arrangements we strongly concur that 'before the placement is effected there be a period of introduction of the child to the carers during which the wishes of the child could be ascertained.'</p> <p>Children in State care who have been sexually abused have multiple, changing and complex needs that need to be supported by a range of appropriately skilled adults who are trained for different roles in relation to the child, but who work collaboratively with other interested parties. Children in this situation need to develop trust over time. Therefore, there needs to be ongoing mental health or counselling support.</p> <p>It is important for support to continue in after leaving care to enable positive transitions into adulthood such as the "Aftercare Resource Centre" programs in Queensland and NSW.</p> <p>Caring for children removed from their families is highly challenging work and carers need to be trained and supported to adequately understand the trauma these children have experienced and how to respond appropriately to ensure that these children feel safe, heard and respected.</p>	<p>[Issue 10]</p> <p>[Issues 5 and 26]</p> <p>[Issues 31]</p> <p>[Issue 5.8]</p> <p>[Issue 5.5]</p> <p>[Issue 30, 31]</p> <p>[Issue 10]</p>

## 5. Service delivery implications and conclusions

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We have suggested in this submission that the sexual abuse of children in State care cannot be considered in isolation from child sexual abuse more generally. Our arguments for this claim are that:

- We know that prevalence of sexual abuse is high and that perpetrators are most often family members or people known and trusted by families.
- Child sexual abuse may have occurred in a family context and be a contributing factor in the removal of a child to alternative care. Abuse may then also have occurred in care. In this way abuse can span the domains of both home and State.
- Even if a child has disclosed the occurrence of sexual abuse (which many do not) the disclosure may well not have been acted on. Silence and secrecy surrounds child sexual abuse and the needs of the victim have often, in the past, not been addressed in any way.
- It is not logical or socially just, within a human rights framework to place citizens who have been abused into two categories, one group which attracts government and policy support and one group that does not.

Relationships Australia (SA) believes that services are required to support both children and adults when they have been subjected to childhood sexual abuse. We emphasise that disclosing sexual abuse is not a 'one off' event and that often people never disclose at all. Living with the effects of childhood sexual abuse is often an ongoing struggle that affects self esteem, relationships with others, trust and the capacity for intimacy.

Sometimes the distress caused by childhood sexual abuse will be signalled or manifested in ways that are not verbal – for example, crying, screaming or attempting to escape the environment in which it took or takes place. In addition, attempts to disclose may occur at different times and in different contexts during a person's life.

The experience of RA (SA) is that when people have access to counselling services that are provided by people with expertise in the area of child sexual abuse and which are focused on the needs of the particular client, outcomes are usually positive.

### 5.1 Services for adults

There are a wide range of services being provided to adults who have been sexually abused as children. These include services in generic settings such as community health centres and women's health services as well as services focused on particular populations or presenting issues. Thus for example, there are services for homeless youth, victim support services, drug and alcohol services, domestic violence services, to name only a few. There are also some specifically funded services for adults which have focused on issues relating to childhood sexual abuse. This includes a service by Uniting Care Wesley Adelaide and the Sexual Offender Treatment and Assessment Programme.

*Respond SA* was established in 2004 and is the most comprehensive response in this area. It is also the only service in this area which has been funded on the basis of short term contracts of 12 to 18 months and which does not have any funding security beyond December 2007. Consequently we focus in this section on the need for this particular service to continue and the need for a specific aftercare service.

#### **Continuation of Respond SA**

*Respond SA* should be retained as a non-government, independent service which has a leadership role in providing the wide range of State-wide services outlined in Section 1. The continued need for this service has been clearly demonstrated in:

- The *Respond SA* Evaluation Report

- Client service figures
- Client Usage and Service Satisfaction Report
- Training provision
- Community education and resource development
- Research on disclosure and help seeking
- Provision of policy advice and involvement in national initiatives.

*Respond SA* provides a “healing centre” for adults who have been sexually abused, including those who were abused as children in State care. In this area it is important to note that clients of the service are often telling of their experiences for the first time. The telling of experience, together with therapeutic counselling provides crucial support which assist clients to “heal” and make sense of their experiences. This support is not time limited. Similarly, it is important to note that people may require support on and off during their life as different life events re-awaken the trauma. The counsellors providing this work are highly skilled professionally qualified people who have additional training in working with this client group to reduce the often damaging effects child sexual abuse has had on their lives. **[Issue 32, 33 and 35]**

For adults who have been abused whilst in State care it is important that this service is provided within an organisational context that has never been involved in providing institution care or foster care. *Respond SA* is a service which provides support to males and females and provides gender specific groups and has been involved in developing a booklet specifically for men. We support the concept that an effective program needs to ensure that its services meet the specific needs of many different groups. This includes specific initiatives for men, for women, for Aboriginal people, CALD, youth and so on. **[Issue 32.7]**

Specific skills are required to work with perpetrators of sexual abuse. The Sexual Offender Treatment and Assessment Programme provides a specialist service in this area. The service aims for clients to “become aware of the cognitive and affective factors associated with their offending behaviour” and where relevant this ensures assisting perpetrators to understand their own childhood sexual abuse. **[Issue 32.8]**

It is also important to recognise that *Respond SA* has been a service which has enabled adults to disclose past childhood sexual abuse to an independent entity and has proactively responded to these disclosures providing information to people on reporting their abuse to the police, legal options available to them and presenting to the CISC Commission of Inquiry.

In relation to services for prisoners **[Issue 39]** it is important to note the services currently being provided by *Respond SA* as outlined in section 1 of this submission. In relation to the issues raised:

- The high incidence of child sexual abuse among prisoners is likely to be accurate.
- Prisoners should have access to counselling services and this is provided to a limited extent by *Respond SA*. In providing counselling to prisoners *Respond SA* has experienced difficulties accessing private rooms for counselling to occur and thus suggests that this situation be rectified so that counselling is not only available but appropriately supported.
- *Respond SA* has provided training to Corrections staff and supports continued initiatives in this area.

As outlined earlier, *Respond SA* has had a major role in provision of training in this area. This is supported by the significant role Relationships Australia (SA) has as a skills training centre for community service and health workers, including foster carer training. Thus, in addition to the current training provided by *Respond SA* it would be possible to extend this training role to also include community education and training on issues relating to working with children.

### ***Funding for an Aftercare Resource Centre***

Relationships SA also recognises and supports the need for specialist support services to be available to people after they have left State care. Once again, we do not believe that services should

be available to one group (those sexually abused in State care) and not also available to other groups who have also been in State care (for example those who may have been abused but not sexually abused). Thus, we propose that support services should be available for all adults who have been in State care. A good example of specialist support services is the Aftercare Resource Centre (ARC) programs in Queensland and NSW which offer a range of assistance in areas of employment, housing, education and counselling. **[Issues 31, 32 and 33]**

This service should provide ongoing support to people who would like assistance dealing with issues which have arisen because of their care experiences.

Services should include:

- Face-to-face and telephone counselling
- Help with records searches
- Assistance with family reunions
- Assistance with educational opportunities and the development of life skills
- Support in accessing housing
- Referral to other services.
- Opportunities for being involved with support groups and other community resources that may be of help.

These services should be available to **all adults who have been separated from their families and placed in State care as a child**. As noted by the Queensland ARC “many former children in care share feelings of sadness, rejection and shame about the past. Many struggle to understand who they are and where they belong, and have difficulty trusting and relating to others.” In addition some will have been subjected to abuse, including child sexual abuse whilst in care.

In addition to an ARC program in South Australia the concept of a range of benefits is supported. **[Issue 33.2]**

## **5.2 Services for children**

Other organisations will be better placed than RA (SA) to comment on the wide range of issues on which the Commission seeks comments in the areas of child protection, therapeutic services for children and out of home care. We therefore confine ourselves to making a few general comments in this area.

When child sexual abuse has been disclosed we strongly support that the needs of the child should be the overarching priority. The child’s needs for safety and wellbeing extend beyond legal and assessment responses and should include mental health and counselling services that are consistent and available in an ongoing way. People delivering such services need particular skills, including the ability to listen to, notice and act upon the priorities, preferences and needs of the child.

RA (SA) supports that service delivery to children should be child-focused in its broadest possible sense, incorporating actual practice where children are themselves viewed as capable of elaborating their own needs. Sorin & Galloway (2006) suggest that ‘the ways in which we view children will shape how we engage with them (or alternatively, attempt to manage them)’. As discussed in the section on Out-of-home care, ‘this is directly relevant to foster care systems and in particular social workers, who must find ways to balance their mandate to protect children with an engagement with what children are actually saying and asking for.’

**Resources to fund therapeutic services for children who have been sexually abused need to be significantly increased. [Issue 26]** Due to a range of factors the State has, by and large, had a reactive approach to engaging with families in which children are sexually abused. As the *Keeping Them Safe* (2004) report notes:

*The evolution in our child protection practices over the last ten years and the current demands mean our system is skewed to the end of the child protection continuum which concerns notification, investigation and legal processes (p. 4).*

Where there are child mental health services, waiting lists are exceedingly long and unable to provide a timely service. We agree with Scott (2006) who suggests that child protection in nations such as Australia largely functions by upholding the rights of children *once abuse has happened*, rather than spending more money and time proactively supporting families *before crises occur*. Scott contrasts this with child protection programs in Western Europe where, she suggests, states use their power to proactively protect and support families.

The existing range of services provides a base on which additional services can be developed if there are sufficient resources to fund their development.

In certain circumstances, where there is evidence that the perpetrator has accepted full responsibility for the abuse and where there are grounds for believing that further abuse is not likely to occur and the child is safe, we support the child remaining in the family home and the perpetrator living elsewhere, and a program of family therapy being undertaken. **[Issue 5.2]**

This service option is supported by research (e.g. Russell-Brown, 2003) which argues for the importance of considering alternate modes of protecting children from abuse such as removing the abuser from the family home, rather than removing the child who, as a result of removal, loses potentially supportive relationships within their family and community, and who must deal with issues of loss and grief in addition to issues of abuse.

We also suggest that removal of the child from the family home may be tantamount to blaming the mother for not protecting her child. Ross (2004) suggests that it is important to distinguish between when birth mothers can and cannot be held responsible for abuse enacted by men in their lives. Simplistic determinations that accord responsibility to all mothers for 'not protecting children' ignore the ways in which some mothers do actually succeed in protecting children and the tactics used by perpetrators to ensure that the abuse remains hidden.

Given the dynamics of abuse however diversionary and family therapy programs for the total family need to be approached with some caution to ensure that the child does in fact remain safe and is not inappropriately pressured. Initiatives in the area of domestic violence have recently been expanded to include a wider range of service options and provide information which is valuable in the consideration of a more complex range of responses to children who have been sexually abused.

We would strongly urge that children be fully counselled about the events that have occurred and told about the range of possible future scenarios regarding their care and schooling and contact with family, relatives and friends. **[Issue 5.6]**

The best interests, needs and safety of victims of child sexual abuse should be the benchmark on which decisions are based about alternative perpetrator programs. The definition of safety for a child who has been subjected to childhood sexual abuse should be broad enough to encompass a range of practical, emotional, and social needs, with an understanding that these needs are not static. **[Issue 6]**

A child should be protected from any suggestion of responsibility about whether or not a perpetrator should participate in a restorative justice program. It must also be understood that the dynamics of control involved in intra-familial child sexual abuse extend beyond a specific act or crime and are likely to impact throughout family and friendship networks and over some time.

RA (SA) believes that counselling services for children who have been sexually abused should be considered as a separate initiative completely independently from the viability of perpetrator intervention programs. **[Issue 5.5]**

## 6. Restorative Justice and Diversionary Programs

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### [Issue 6]

Professional practice experience with adult survivors of childhood sexual abuse and research within Relationships Australia (SA), gives rise to some caution about the concept of restorative justice in relation to child sexual abuse. Nevertheless, we do support this issue as an initiative which warrants further research and discussion.

As we understand it, the approach advocates bringing the victim and the offender together, 'back into their respective positions' before the crime was committed, in order to bring about understanding of the circumstances of the other person' [CISC *Issues*, p.14).

The CISC *Issues* document suggests that a restorative justice approach may be considered in appropriate cases and that it would require that the perpetrator acknowledge guilt and observe strict conditions, for example, in relation to employment and living arrangements.

The thinking behind this approach is that children may then be able to remain in their home and within their social network. In addition, if charges were not laid, the children would not have to be involved in the criminal justice system. Such arrangements would also offer potential cost saving, if the criminal justice system and/or the custodial system are not employed.

Relationships Australia (SA) strongly supports the idea that the safety and wellbeing of the child must be the first priority in any response or intervention. At the same time we acknowledge that removing a child into alternative care, can cause additional trauma and dislocation in a child's life.

It is our view, however, that regardless of any rehabilitation program that is employed, or considered, if a perpetrator of child sexual abuse has acknowledged guilt or where there is sufficient evidence suggesting guilt, **then the alleged offender should be prosecuted through the criminal justice system. While a prison sentence may be suspended a conviction should occur. It is imperative that child sexual abuse is not de-criminalised.**

Relationships Australia (SA) supports the concept of exploring possibilities for the implementation of alternative offender programs (both within and outside of prisons). As noted in Layton (2003)<sup>14</sup>, given the high rate of recidivism and the large number of acts of child sexual abuse per offender,

it is to be hoped [with the implementation of treatment programs for offenders] that many children would be spared exposure to sexual abuse and in turn be more likely to spare other children.

The Layton report also acknowledges however, that such programs are not without their difficulties.

While there may be a place for pre-trial diversionary programs for perpetrators of intra-familial sexual abuse, RA (SA) urges extreme caution about 'bringing the victim and offender together' to facilitate mutual understanding. We are concerned here that children will be given an additional burden, namely being required to understand sexually abusive adult behaviour. Further we are concerned about the power dynamics inherent in the sexual abuse children by adults, the powerlessness of the child, the pervasive effects of offender tactics and acute sensitivity of children (and adult survivors) to further pressure and coercion.

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<sup>14</sup> Layton, R (2003) *Our best investment: A State Plan to Protect and Advance the Interests of Children*, Chapter 16:5.

The dynamics of this manipulation go beyond the actual act of abuse, and victims are often intimidated in a range of covert ways including being made to feel responsible for keeping their family together. As O'Connor (1991) points out:

*The process of sexual abuse can be subtle and binding. With a significant number of incest victims, the child may love, need, or depend on the perpetrator (Section 4.5).*

Factors such as these are central to the consideration of the best interests of the child who has been subjected to childhood sexual abuse.

There exists a significant body of work, in research, practice, and policy that has been undertaken in the field of domestic and family violence since the early 1970s, both within Australia and internationally. Many of the issues raised in this domestic violence work parallel questions and issues in the area of child sexual abuse. It is also important to note that the current degree of governmental and community awareness and action in relation to domestic violence has come about over many decades and largely as a result of the efforts of activists, researchers and workers in the field.

Julie Stubbs has argued that denouncing domestic violence has been an important gain and should not be undermined (2004, p.9). Similarly, we argue that denunciation of child sexual abuse as a crime and the recognition of the rights of children have been relatively recent gains following much hard work by advocacy groups. It is very important that this progress is not confused or jeopardised in any way and thus we support a cautious and well researched approach to the adoption of a restorative justice model in this area.

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