Submission to the
Senate Community Affairs Committee

Commonwealth Funding and Administration of Mental Health Services

Bravehearts inc.
Educate. Empower. Protect.

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About the Authors

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Hetty Johnston is Founder and Executive Director of Bravehearts Inc., whose purpose is to provide therapy, support and advocacy services to survivors of child sexual assault. Hetty is the author of the national awareness campaign, "White Balloon Day", the "Sexual Assault Disclosure Scheme", the "Ditto's Keep Safe Adventure!" child protection CD-Rom and her autobiography, "In the best interests of the child" (2004). In 2005, Hetty was announced one of four Queensland finalists for the 2006 Australian of the Year Awards.

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About Bravehearts Inc.

Bravehearts Inc remain Australia's leading child protection advocates in the area of child sexual assault and are recognised as such nationally by governments, media and the community at large. We remain the only registered PBI dedicated holistically and specifically to the issue of child sexual assault as it occurs in Australia.

Founded in 1997 by Hetty Johnston, Bravehearts Inc. has evolved into an organisation whose purpose is to make Australia the safest place to raise a child. We do this through providing therapeutic, support and advocacy services to survivors of child sexual assault, and through education, prevention, early intervention and research programs relating to child sexual assault.

Bravehearts operates at a National level, from our Head Office on the Gold Coast, advocating and lobbying across the country, with a physical presence in four States: Queensland (Gold Coast, Brisbane and Cairns), New South Wales (Sydney and Shoalhaven), Tasmania (Launceston) and Victoria (Shepparton).

Bravehearts moves towards its goal by:

- Assisting children and their non-offending family members to recover from the trauma of child sexual assault through therapy, advocacy and support;
- Raising awareness via initiatives such as the 'White Balloon Campaign' - a public awareness and child protection initiative;
- Protecting survivors and providing them with avenues of redress through projects like the 'Sexual Assault Disclosure Scheme' (SADS) – a means for anonymous yet official disclosure of assault;
- Providing and developing effective education and prevention programs (Ditto's Keep Safe Adventure) to empower children and young people and increase their resiliency to child sexual assault;
- Provision of professional training and workshops; including specialised training for therapists and professional development for organisations that work with, or who's core business involves children;
- Advocating for survivor's rights through participation in legislative review and reform (successful campaigns include: the introduction in Queensland, New South Wales, Western Australia, Victoria and South Australia of Continuing Sentences for dangerous paedophiles; the closure of Queensland's Department of Family Services; the introduction of Section 189, the right for children and their families to speak publicly; the introduction of the Amber Alert system in Australia; the instigation of various formal Inquiries; and successful amendments to legislation);
- Proactive involvement in cyber-safety initiatives, including a presence on the Federal Government's Cyber-Safety Consultative Working Group;
- Raising community awareness through participation in public debate and in the accumulation, production and dissemination of relevant research material; and
- Supporting the work of other agencies (government and non-government) and individuals in their work around child sexual assault.

Introduction

Bravehearts strongly believes that in order to properly and effectively address mental illness in our community, it is crucial that we provide early intervention strategies that address the causal factors and manage the potential effects of adverse childhood experiences. As an agency that is focussed on advocating for appropriate and effective responses to child sexual assault, our comments are made within this context.

The Impacts of Child Sexual Assault

One in three girls and one in six boys will be sexually assaulted in some form by the age of 18 (Australian Institute of Criminology, 1993). These figures have been consistently reported over the past decade. For background to our submission, we provide the following facts surrounding child sexual assault:

- Based on a review of research conducted on child abuse between 2000 and June 2008, researchers estimate that… between 5 and 10% of girls and up to 5% of boys are exposed to penetrative sexual assault, and up to three times this number are exposed to any type of sexual assault. (Gilbert, Spatz-Widom, Browne, Fergusson, Webb & Janson, 2009)
- Research shows a staggering 45% of women aged 18-41 were sexually assaulted as children by family members (30%), friends or family friends (50%) or strangers (14%). 75% of the abuse involved some contact, most of which was shockingly severe. (Watson, B., Griffith University, Herald Sun, 9th October, 2007)
- It is estimated that 1 in 4 girls and between 1 in 7 and 1 in 12 boys are victims of sexual assault. (James, 2000)
- Girls and boys of all ages are sexually assaulted and victims are sometimes toddlers, young children and even babies. (NSW Child Protection Council, 2000)

Child sexual assault has long been recognised to have a key relationship to later mental illness. The mental health system is filled with survivors of prolonged, repeated childhood trauma:

- Women with a history of child sexual assault were more likely to use mental health services, pharmacy services, primary care services and speciality care. (Bonomi, 2008)
- Among male survivors of child sexual assault, more than 70% seek psychological treatment for issues such as substance abuse, suicidal thoughts and attempted suicide. Males who have been sexually assaulted as children are more likely to violently victimize others. (Walrath, Ybarra, Holden, Liao, Santiago, & Leaf, 2003)
- 50 to 70% of all women and a substantial number of men treated in psychiatric settings have histories of sexual assault or physical abuse, or both. (Bryer et al., 1987; Craine et al., 1988)
- As high as 81% of men and women in psychiatric hospitals with a variety of major mental illness diagnoses, have experienced physical abuse and/or sexual assault. 67% of these men and women were abused as children. (Jacobson & Richardson, 1987)

- 97% of mentally ill homeless women have experienced severe physical abuse and/or sexual assault. 87% experienced this abuse both as children and as adults. (Goodman, Johnson, Dutton & Harris 1997)
- Childhood abuse can result in adult experience of shame, flashbacks, nightmares, severe anxiety, depression, alcohol and drug use, feelings of humiliation and unworthiness, ugliness and profound terror. (Harris & Landis, 1997; Brown & Finkelhor, 1986)
- The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were sexually assaulted and/or physically abused as children. (Herman et al, 1989; Ross et al, 1990)
- Women molested as children are four times more at risk for Major Depression as those with no such history. They are significantly more likely to develop bulimia and chronic PTSD. (Stein et al, 1988; Root & Fallon, 1988; Craine, 1990)
- Adults abused during childhood are (Stein et al, 1988):
  - more than twice as likely to have at least one lifetime psychiatric diagnosis
  - almost three times as likely to have an affective disorder
  - almost three times as likely to have an anxiety disorder
  - almost 2 ½ times as likely to have phobias
  - over ten times as likely to have a panic disorder
  - almost four times as likely to have an antisocial personality disorder

There is also a highly significant relationship between childhood sexual assault and various forms of self-harm later in life:

- Young people who had experienced child sexual assault had a suicide rate that was 10.7 to 13.0 times the national Australian Rates. A recent study of child sexual assault victims found 32% had attempted suicide and 43% had thought about suicide. (Plunkett, Shrimpton & Parkinson, 2001)
- Young girls who are sexually assaulted are 3 times more likely to develop psychiatric disorders or alcohol and drug abuse in adulthood, than girls who are not sexually assaulted. (Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000)
- For adults and adolescents with childhood abuse histories, the risk of suicide is increased 4 to 12-fold. (Felitti et.al., 1998)
- Teenagers with alcohol problems are 21 times more likely to have been sexually assaulted than those without such problems. (Clark, Lesnick & Hegedus, 1997)
- Nearly 90% of alcoholic women were sexually assaulted as children or suffered severe violence at the hands of a parent. (Miller and Downs, 1993)
- Most self-injurers have childhood histories of physical abuse or sexual assault. (Briere and Runtz, 1988)
- Adults abused during childhood are more than twice as likely than those not abused during childhood to have serious substance abuse problems. (Stein et al, 1988)

Taking Child Sexual Assault 'Out of the Pot'

Recommendation 1: Bravehearts calls for the issue of child sexual assault to be recognised as distinct from child abuse and neglect as part of the National Mental Health Reform.

Bravehearts long held belief and policy position that the issue of child sexual assault and those of child abuse and neglect are discernibly different and require discernibly different responses has finally been heard and upheld by the Council of Australian Governments (COAG) on 30th April,2009 in the National Framework for Protecting Australia's Children 2009-2020.

In working with the Federal Governments Working Party in the development of a National Framework for the Protection of Australia's Children, and in what we believe is an International first, Bravehearts successfully lobbied to have child sexual assault recognised as distinct from child abuse and neglect and requiring of a distinct response and specific resourcing. The signing of the COAG Agreement means this distinction will now be echoed across child protection systems in every State and Territory around the Nation. The National Framework will form the basis of child protection agendas over the next decade. Outcome Six of this document outlines the way forward for finally dealing with child sexual assault. Governments across the country are now finally committed to recognising and responding to child sexual assault specifically.

Traditionally, child sexual assault has been 'lumped in the same pot' as child abuse and neglect. However, while all forms of abuse and assault are harmful to children it is important to take child sexual assault 'out of the 'pot' as the dynamics are fundamentally different. Recognising these differences is necessary to effectively address, respond to and prevent child sexual assault.

Some of the important differences include:

- Acts of ***child abuse and neglect*** are generally unplanned, re-active and are generally aligned with socio-economic and/or family dysfunction issues and are comparatively predominant in areas of social disadvantage.
  Sexual assaults against children are almost always pre-meditated, involving predatory acts of grooming, manipulation, self gratification and exploitation, and occur widely across the various socio-economic areas.
- ***Child abuse and neglect*** more commonly involve the infliction of pain, violence and aggressive force.
  Child sexual assault more commonly involves manipulation, intimidation and sexual contact.
- ***Child abuse and neglect*** are nearly always perpetrated by a parent or primary caregiver (in an estimated 90% of cases).

Child sexual assault is generally perpetrated by a male (in excess of 90% of cases) and more likely to be perpetrated by someone known to the child or their family (research varies but commonly finds between 85% and 95% of the time). Of those offenders known to the child most commonly the offender is not living with the child (approx 70%).

- ***Child abuse and neglect*** offences are almost always intra-familial.
  Child sex assault offences are commonly extra-familial as well as intra-familial.
- ***Child sexual assault*** always involves the three S's: **Shame; Silence; Secrecy**

Specialist Training for Therapists

Recommendation 2: Bravehearts calls for funding for mental health reform to ensure funds for the professional development training in the area of child sexual assault for all mental health workers.

Child sexual assault is a hidden but significant problem in every community in Australia. Experts estimate that one in five children will be sexually assaulted before their 18th birthday. Less than one in ten will tell. Research clearly shows that individuals who are sexually assaulted as children are far more likely to experience psychological problems, often lasting into adulthood, including Post Traumatic Stress Disorder, depression, substance abuse and relationship problems.

Ensuring that there is specialised and effective therapeutic support for survivors of child sexual assault is essential, yet there is a recognised gap in the training of therapists (psychologists, counsellors, social workers) in the area of child sexual assault. This has been recognised in Outcome 6 of the National Framework for Protecting Australia's Children 2009-2020. Effective intervention and support can only occur if professionals working with these children are properly equip to deal the specialised nature of this work.

In 2009, the Federal Government provided funding for Bravehearts to deliver our Practitioner Workshop, based on 12 years of specialist experience, across the country. The workshops run in 2009 were fully booked, with a wait list created. The uptake of these training opportunities exceeded any expectation and it is clear that specialised training in this area is desperately needed. Bravehearts believes that it is critical that monies set aside in the National Mental Reform for highly successful professional development training to continue.

The Bravehearts' workshop is aimed at training participants to work effectively with victims, and increases both practitioner knowledge and confidence in responding to those affected by child sexual assault, with core focus on:

- Understanding the nature of child sexual assault;
- Strengthening therapeutic approaches to children affected by sexual assault;
- Effective therapeutic interventions with children who have experienced sexual assault;

- Understanding the principles behind psycho-educational tools to teach personal safety messages to children;
- Effective responses to disclosures of sexual assault within the therapeutic environment;
- Supporting parents to respond appropriately and effectively to disclosures, as well as behaviours and emotions often associated with child sexual assault;
- Understanding the toll on the therapist when working in the area of child sexual assault and identifying key self-care and organisational-care strategies to minimise this effect.
- Tailoring therapeutic responses to participants' workplace settings..

These training workshops have further been developed to include:

- Ongoing telephone and network support for practitioners
- Online updates, including latest research and therapeutic techniques.
- Additional workshops for: parents and carers; teachers, child care workers and others working with children; general practitioners and health workers; child protection workers and carers.

In late 2011, Bravehearts will be publishing a "toolbox" for practitioners through Australian Academic Press. This book will be an essential guide for general counsellors, school counsellors, psychologists, youth workers, chaplains, mental health practitioners and other allied health professionals, to provide them with the necessary information and skills to support children and young people affected by sexual assault.

With effective training programs in place, we believe that funding of a "locum-style" model, would be a cost-effective approach to ensure that trained, specialised therapists would be able to reach those in remote or rural areas, or areas where specialised child sexual assault counselling is just not available.

Adequacy of Funding for Disadvantaged Groups

Recommendation 3: Bravehearts calls for sufficient mental health funding for specialist child sexual assault counselling.

There is an ongoing gap in specialised therapeutic services for children, young people and adults who have experienced child sexual assault and an increasing demand for skilled and relevant counselling. Survivors find that they are referred from one service to another in a vain effort to find appropriate and affordable care. The lack of services means that survivors are unable to receive appropriate information and professional care. This has had disastrous consequences for many who, having spoken about the sexual harm perpetrated against them, continue to feel a great sense of isolation or blame themselves for the abuse.

The majority of courses and degrees in counselling and related work provides training in a method that is expected to apply to people with all types of problems. This is because most therapists work in some sort of 'general practice'. The effects of child sexual assault are far-reaching, the dynamics of the offending and the harm are complex.

Clinical intervention in child sexual assault requires an understanding of the phenomenon – what it is, how it happens, when it is likely to occur and why, what circumstances determine disclosure and how victims are likely to be impacted. For example, child sexual assault usually involves a process of grooming and contrived compliance based on trickery, manipulation and secrecy with a child whom the offender usually has a close relationship to. Understanding these offending components, it becomes clearer how easily children can become coerced into silence, or indeed made to feel some responsibility in the offence.

For example, Bravehearts works from a person-focused strengths-perceptive, which is influenced by expressive therapeutic processes and techniques. This model of counselling is strongly supported in literature on child sexual assault and therapeutic approaches. It is important that therapists do not play the ole of investigator and ask direct questions about the how's, what's and why's of the assault, as this approach can ultimately damage police investigations and prosecutions of offenders

The importance of being able to access specialised therapeutic support for victims of child sexual assault cannot be overstated. Ineffective therapeutic responses can result in victims trauma being compounded.

Funding of "locum-style" model, would be a cost-effective approach to ensure that trained, specialised therapists would be able to reach those in remote or rural areas, or areas where specialised child sexual assault counselling is just not available.

Impact of Online Services

Recommendation 4: Bravehearts calls for clear guidelines to be introduced for online therapeutic services, that include a focus on preparing the client for face to face counselling.

The use of the Internet to provide mental health services is controversial. While people who can not or will not present for face to face counselling may utilise online services, the therapeutic benefit of such approaches is still questionable and proven.

There are positive aspects to online services, clients may be more easily able to honestly open up around issues that may be difficult to speak about. However, clients can also more easily omit crucial information about themselves, their problems, and their feelings, making it almost impossible for the therapist to know, or detect, a resistance to disclose. The potential for the therapist to pick up on the clients resistance, which is often detected in nonverbal behaviour, such as looking away, shifting in a chair, and other body language, is an issue that faces online therapists.

In addition, once a professional relationship has been established, the licensed clinical psychologist or mental health professional has a responsibility to the welfare of the client. It is unclear how this can be executed completely through an online relationship.

There are, of course, particular implications for therapeutic interventions in the area of complex trauma such as chid sexual assault and in providing effective counselling for children and young people.

Bravehearts strongly believes that while there are positive aspects to utilising the online environment, this is not the most effective method for providing services targeted towards children and young people, particularly those with trauma resulting from harms such as child sexual assault. It can serve as a useful tool for therapists to connect with clients and prepare them for face to face counselling.

We acknowledge that where no other alternative presents, the provision of online counselling services is preferable to no service provision. However, as discussed above, we believe that funding of "locum-style" model, would be a cost-effective approach to ensure that trained, specialised therapists would be able to reach those in remote or rural areas, or areas where specialised child sexual assault counselling is just not available.

Prevention Programs

Recommendation 5: Bravehearts calls for sufficient mental health funding to be quarantined for prevention programs.

Services providing education and prevention around child sexual assault are a fundamental key to achieving long-term reductions in the devastating impact of this crime on the mental health statistics.

The resourcing of education and prevention is crucial. Budgetary allocations need to be made to fund proven, effective programs that demonstrate best practice.

Public awareness of the problem of child sexual assault has grown to a point whereby concerns have emphasised the need for widespread preventative programs to be implemented. In 1997 the Woods Royal Commission recommended a focus on the "broad community education programs including information on children's rights, empowering children to speak out, to say NO to adults, to understand their bodies and their rights around the touching of their bodies". In line with this, a strong feature of the published research on personal safety programs has been the evidence that suggests that preventative strategies are far more cost effective than trying to fix the problem after the fact.

Accordingly, school-based personal safety programs have emerged increasingly over the last two decades across the US, Canada, NZ, UK and Australia (Briggs & Hawkins, 1994; Browne & Lynch, 1994; Poole & Tomison, 2000). Effective, evidence-backed, school-based personal safety programs play a vital role in preventing child sexual assault, equipping children with the knowledge and skills they need to identify unsafe or risky situations, and giving them an understanding of their rights to protect themselves and their own body.

The introduction of personal safety education within schools appears to be a logical progression. Not only do schools have the ability to reach large numbers of children at the one time, but their primary purpose is to be a place of learning. In schools children are taught how to stay safe in traffic, how to stay safe from fire, water and electricity; it was logical that schools should progress to also teach children how to stay safe with people.

While personal safety is embedded in curriculum in most States and Territories, the effective teaching of these skills eludes most classrooms. Teachers are often ill-equipped and frightened to approach this subject in the classroom. The majority of feedback Bravehearts has received on our program is gratitude for providing teachers with the language and methods to discuss personal safety.

W are currently working with education departments in Queensland and Tasmania, with interest expressed by other States and Territories, to support teachers to provide these programs in schools.

Bravehearts' *Ditto's Keep Safe Adventure* (DKSA) program is an example of the incredible impact of prevention programs in this area. The external evaluation determined that the *Ditto's Keep Safe Adventure* program **has the potential to reduce child sexual assault by up to 50 per cent**. The program is not "sex education" and does not discuss sexual assault, focussing on key personal safety messages. The impacts of the program have seen children disclose not only child sexual assault but also domestic violence and bullying situations.

Since 2008 Bravehearts continues to receive Federal Government funding to deliver the program to Indigenous children in the Cairns and Far North Queensland regions.

As well as including already established and effective protection principles, the DKSA school-based program incorporates a set of learning objectives informed by research on disclosure principles and child sexual offender behaviour. The DKSA model covers: differentiating between 'yes' and 'no' feelings (reinforcing children's natural emotional regulation); recognising 'warning' signs (identifies the emotional and physiological responses to potentially threatening experiences); identifying private parts (the importance of teaching children which parts of their bodies are exclusively theirs has been supported by research, as offenders often exploit children's lack of knowledge); identifying secrets (the inclusion of secrets is considered important as secrecy plays such a fundamental role in child sexual assault); and identifying what to do if they feel unsafe or unsure in situations (gives children the knowledge that they are allowed to tell

someone if they are not feeling safe). The program includes highly effective songs, with lyrics informed by linguistic knowledge and input.

The promise of child sexual assault and child abuse prevention is that it effects savings in several important areas. The most obvious savings are, of course, in the lives of the children who will not suffer the devastating effects of sexual assault or child abuse. Through prevention we can save the staggering amounts of money spent annually dealing with the mental health consequences.

ATAPS and Child and Youth

Recommendation 6: Bravehearts advocates for simplifying the process of accessing ATAPS funding.

We feel it is imperative that the referral process for Access to Allied Psychological Services funding be as streamlined and seamless as possible to reduce the stress to the family and further ensure the success of this funding.

It is our understanding that a diagnosis of a mental health disorder is required to access the funding under ATAPS. In relation to funding therapeutic support for children and young people, we would caution against a formal diagnosis for several reasons:

- Firstly the long term impact of labelling a child with a mental health disorder can be detrimental to identity development and may therefore create ongoing mental health difficulties;
- Secondly it may make it more difficult for clients and their families to quickly and seamlessly access counselling services if they also require a diagnosis prior to becoming eligible for services; and
- Finally, diagnosis is not necessary for treatment to be effective and relevant.

If a formal diagnosis is required, it is our position that this adds a problematic layer to the process. A general practitioner is not often qualified to provide a formal diagnosis of a mental health disorder and access to specialists or clinical psychologists is often unaffordable for families and plagued by extensive waiting times.

Further, we believe that children and young people who have been sexually assaulted can experience significant levels of trauma and impact from the assault, without the development of a diagnosable mental health disorder. These victims still require access to therapeutic services and there is a significant lack of free or affordable specialist programs (see *Adequacy of Funding for Disadvantaged Groups* above).

It is our position that children and young people affected by sexual assault often require access to therapeutic support as a preventative measure. We would advocate that funding not be based on the diagnosis of a mental health disorder, as the objective, particularly with our clients, should be the prevention of the development of a mental health disorder.

In addition, underpinning the ATAPS funding is a requirement for the client to have a GP visit/referral prior to being eligible for counselling.

We found that currently there are multiple access points to counselling for children/families who are experiencing mental health problems. Any one of those listed below (not exhaustive list), may identify or be responsible for onward referral to counselling services.

- School – teacher, principle, guidance officer
- Police
- Department of Child Safety
- General Practitioner
- Directly from the parent
- Counselling services
- Community Agencies

If to access ATPAS funding a child or family is required to obtain a referral from a GP this may result in the re-telling of the event to numerous services. For example, a typical scenario may be:

> *13 year old Caitlin reports to her school guidance officer that her 17 year old cousin sexually assaulted her. The guidance officer tells Caitlin that they need to talk to her parents. With the school guidance officer's support, Caitlin recounts what happened to her parents and they take the matter to the Police where Caitlin is formally interviewed. The police suggest that the family contact Bravehearts for therapeutic support. The family attends Bravehearts and it is suggested that they may be eligible for financial support through Medicare. Caitlin and her family attend their GP for a referral for counselling under ATAPS.*

We feel that if a child/family is required to visit multiple services and re-tell their story prior to obtaining counselling that this could be detrimental to the success of this funding; as well as to any potential following police investigation or prosecution. Families who have children that are experiencing mental health problems are often under a significant amount of stress, and asking them to navigate a complicated or lengthy referral process would only serve to add more stress.

We would recommend that a potential solution for this concern would be to allow GPs to accept recommendations from recognised services that a referral be made for ATAPS, without requiring the child/family to re-tell their story.

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