CONSENSUS STATEMENT

BY THE MENTAL HEALTH COMMISSIONS OF AUSTRALIA TO THE ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE

Australian Government
National Mental Health Commission

Mental Health Commission of New South Wales

Queensland Mental Health Commission

Government of South Australia
SA Mental Health Commission

Government of Western Australia
Mental Health Commission

Introduction

This consensus statement by the mental health commissions of Australia is intended to identify the essential elements that will need to underpin the recommendations of the Royal Commission in respect of the mental health impacts of institutional child sexual abuse.

At the outset let us state that being abused is not a mental health disorder – it is a human rights violation which can and often does profoundly negatively impact a person's mental health. People have had their dignity violated and their safety and security shattered by repeated extreme interpersonal trauma. People who have been abused often want to see justice delivered. This cannot be overlooked.

The mental health commissions of Australia acknowledge the strength, courage and resilience of survivors of childhood sexual abuse.

The Royal Commission into Institutional Responses to Child Sexual Abuse in Australia highlights the devastating impact on children, and on the adults they become when institutions betray the trust placed in them and fail to keep children in their care safe. Most importantly, the evidence before the Royal Commission shows that this is not a historical problem; nor is it an isolated one. We need to ensure that the services and systems established in response to the recommendations of the Royal Commission not only provide better responses to adult survivors, but that they also optimise opportunities for children and young people to disclose as early as possible and receive the right response and care. This is not just the responsibility of specialist services; organisations including government agencies, welfare groups, schools, sporting clubs, religious bodies, youth and social groups, all play a vital role in the safety, health and wellbeing of children and young people.

Victims of child sexual abuse can suffer many mental health challenges as a result of their trauma, both immediate and over the course of their life. They can struggle to feel and be safe, and to trust as their capacity to do so has been eroded. They can feel distressed and angry that they weren't protected by those charged with their care. Often they experience a lot of shame and can blame themselves, believing the abuse was in some way their fault, or as a result of doing something wrong. Of course children are never to blame for their abuse. The impact of abuse and/or neglect differ enormously depending on a complex interplay of factors including but not limited to the following variables: disposition; resilience; bio-psychological factors; family environment and other supports; peers; security; positive parent/child attachment; and abuse history, including duration, frequency and nature of abuse. However, recovery is possible and many people go on to lead fulfilling lives.

In designing systems and services which are attuned to the particular vulnerabilities of survivors of child sexual abuse and other childhood trauma, it is important to use a trauma lens which recognises the complexity and sensitivities and minimises the risk of re-traumatisation. The complexity of unresolved trauma and associated mental health impacts has important implications for the way in which services are delivered and the way in which those affected engage with services.

The Royal Commission has uncovered the shocking scale and stakes of childhood trauma. The task of providing adequate services to everyone identified, and those yet to be identified, could appear daunting. However, the task is not unmanageable. In fact, many people so affected are already engaged with diverse services e.g. receiving the disability support pension, accessing health services for chronic pain, engaged with child protection, mental health, welfare or justice services. However, they are often not getting the optimal response because services generally do not recognise or respond well to unresolved trauma. This population can become the 'revolving door' or 'helpless' cases, who become perceived judgmentally, including amongst staff of the services intended to support them.

With the right type of care and support, however this group can be appropriately supported to reengage with the community, and so deliver significant social, emotional and economic benefits.

Essential elements

1. Childhood trauma is broader than institutional sexual abuse

Institutional child sexual abuse is, unfortunately, a small percentage of child sexual abuse presentations, with the majority of child sexual abuse occurring in the home and family. This, in turn, is a smaller proportion of the total population of people who experience childhood trauma of various types. While it is appropriate that the focus of the Royal Commission is on the response needed for victims of institutional sexual abuse, if we get the response right for this population, we have the opportunity to get it right for the broader population who have experienced childhood trauma, more generally.

2. Recognise strength and resilience

The strength and resilience of survivors of childhood sexual abuse is an important foundation on which to build. This strengths-based approach emphasises the existing resources of the person and focuses on skill development rather than a deficit model of illness or symptoms. This approach is integral to providing trauma-informed care which is based on five foundational principles: safety, trustworthiness, choice, collaboration and empowerment.

3. Build trauma capability across the full spectrum of services

It is essential to build the knowledge, capacity and skills of all people working across health and human services to identify, support and appropriately refer survivors of child sexual abuse. This requires staff training at all levels and coordination between mental health and diverse services to ensure the appropriate support and referral pathways are known and accessed to meet the specific needs of the person. Poor responses to tentative attempts by survivors to speak out and seek help can be highly traumatising, and discourage further attempts at help seeking.

Characteristics related to the abuse, such as difficulties trusting institutions can factor into people's engagement or otherwise with services. For example, hospital-based services dominated by the often hierarchical bio-medical model, and which do not consider a survivor's lived experience, are likely to be very triggering and make abuse victims feel unsafe. Community and outreach supports should also be sensitive, supportive and non-clinical.

Trauma-informed services are needed across all life stages and diverse services and systems. As trauma survivors age, many specifically fear re-institutionalisation, triggering prior traumatic experience.

4. Develop coordinated responses

Develop coordinated responses that foster services to cooperate between systems and funding streams. In addition to mental health, survivors often need access to justice, financial support and a broad range of social supports, for example, support in accessing and maintaining education, employment and housing, and general support for building social connectedness.

The current system is highly siloed and does not adequately respond to the complex diversity of need many survivors experience. Funding is provided for defined services, which are often driven by diagnosis, or presenting behaviours and with clearly demarcated outcomes. The system rarely works strategically and collaboratively to privilege an individual’s holistic recovery across the life cycle. For example, alcohol and other drug services often only engage with problematic substance use issues, without addressing co-occurring mental health issues or underlying trauma. Similarly mental health services often do not provide drug and alcohol support, and fail to identify and address unresolved trauma. This inevitably results in both poorer outcomes for the individual, and a greater cost to the service system and the broader community.

A significant opportunity exists in the move across Australia towards regional/ local service planning. The recent re-organisation at the Commonwealth and state level in terms of Primary Health Networks (PHN) and Local Health Districts (LHD), provides a real opportunity of planning at the local population level to meet local needs provided the PHNs and LHDs work collaboratively and with other relevant agencies at the regional level. And provided trauma-informed approaches are embedded within and across service systems.

5. Increase the capacity of phone and online services

Many people find the anonymity of telephone and/or online services preferable, particularly when trying to deal with the shame and stigma of having been abused. The importance of specialist services with the experience and expertise to support adult survivors of child sexual abuse and other traumas cannot be understated.

Significant advances are occurring in the delivery of online mental health services. They can be anonymous and can provide not only information but also counselling interventions for immediate support and referrals to specific services. Examples of this include: MindSpot run through Macquarie University; Reachout.com for young people; and the Synergy trials being funded by the Commonwealth government and run by Brain and Mind Centre. Although these examples do not pertain to the complex needs of survivors, they are good examples of tools that can be employed.

When people do seek help, current services (including GPs, other primary health access points and crisis services such as Lifeline and Kids Helpline) need to be supported by training to ensure they can identify and appropriately support and refer people who have experienced child sexual abuse to specialist services such as Blue Knot Foundation.

6. Provide ongoing support

Access to ongoing therapeutic support with a trusted professional is often critical to recovery.

Survivors of child sexual abuse often find it difficult to form and sustain relationships. As children they might have been betrayed by the very adults who were meant to nurture and protect them.[1] Supporting people to experience relationships differently is an important part of recovery but this takes time with consistent and predictable relationships.

---

[1] blue knot foundation, “How can abuse affect me?”, access via http://www.blueknot.org.au/Survivors-Supporters/For-Survivors/Resources-for-Survivors/How-can-abuse-affect-me

Indeed, providing too few counselling or support sessions may in and of itself cause harm – the person has commenced the treatment process towards recovery but needs to terminate the process prematurely because their sessions run out. This can reinforce common issues of abandonment by people with whom they have developed trusting relationships (in this case their psychologist/counsellor). The person needs both trauma specific services and adequate *dosages* of service, for as long as is required to facilitate the recovery process.

One significant gap is the limit to the number of funded Medicare psychology sessions. People with complex trauma may require many months of support, but currently Medicare reimbursement is capped at 10 to 18 appointments depending on the scheme. Access to psychological treatment in the community is growing and well linked to GP practices, however treatment can be expensive and difficult to access. Funding to support longer term treatment would allow some to get the care they need.

7. Prepare for increased demand

The process of the Royal Commission will have raised victims' expectations that appropriate services will be provided to meet their needs. Accordingly, governments can expect an increase in demand for services on an ongoing basis, whether through a redress scheme or otherwise.

There will need to be a mechanism for ensuring that the people who have engaged with the Royal Commission receive the services they need. This will require sensitive follow up. Whatever is put in place should not operate as another layer of regulation, but provide a coordination and support function. It should bring together all the relevant players to ensure there is a consistent approach for providing support and healing. This would enable survivors to know about the variety of services and supports that are appropriate for them, as well as ensuring that the work of the Royal Commission is honoured in terms of survivor support for recovery. There will be important lessons from such an approach that could be applied across the service system.

The Royal Commission has and will also raise issues for people who have not engaged with the Commission but have suffered childhood abuse. A system that encourages them to access the support they need is essential.

8. Increase community based support workers

What we say here is not new, these suggestions are given time and again whether it is a review of the mental health system, the disability support system or the child protection system. What is missing are resources across a range of services. One glaring gap for achieving what is set out here is funding for community based support workers, akin to case managers, social workers and/or youth workers, including those with a lived experience of childhood trauma. Staff whose sole job is to be a regular point of contact, a familiar face who knows the whole story, connecting people with the services they need and ensuring those services are provided in a coordinated way.

Positive relationships can make a significant difference for survivors of trauma. Engaging in relationships that are positive and sustaining, which is the role of community based support workers, can counteract the consequences of poor connective experiences.

9. Develop culturally appropriate services

Many Aboriginal people, across the whole community, have negative relationships with institutional settings, such as mental health services or hospitals. This is due to a range of factors including the exacerbation of intergenerational trauma and previous traumatic experiences in such settings.

To support Aboriginal people to access the right type of care we need partnerships among service providers, both mainstream and Aboriginal community controlled. Effective and meaningful partnerships must be a priority for leaders in government and community managed agencies.

Resources for building the Aboriginal health workforce need to be an urgent priority. This includes providing Aboriginal health professionals with adequate culturally appropriate support and mentorship, which incorporates trauma-informed principles into a healing model.

Aboriginal communities should be empowered to develop ground-up approach, owned and promoted by the communities, including Aboriginal people with lived experience.

John Feneley, Commissioner, Mental Health Commission of NSW

16 June 2017

On behalf of:
Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission
Dr Lesley van Schoubroeck, Commissioner, Queensland Mental Health Commission
Mr Chris Burns, Commissioner, Mental Health Commission of South Australia
Mr Timothy Marney, Commissioner, Mental Health Commission of Western Australia