

Service and support needs of specific population groups that have experienced child sexual abuse: Report for the Royal Commission into Institutional Responses to Child Sexual Abuse
July 2016



Never Stand Still

Gendered Violence Research Network

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The Royal Commission into Institutional Responses to Child Sexual Abuse commissioned and funded this research project. It was carried out by Associate Professor Jan Breckenridge and Gabrielle Flax.

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EXECUTIVE SUMMARY

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) contracted researchers from the Gendered Violence Research Network (GVRN) at UNSW Australia to provide a literature review on the support needs of specific population groups affected by institutional child sexual abuse.

Two core questions were agreed with the Royal Commission to comprehensively address the focus of the literature review. These were:

Question 1: Do different groups of survivors have distinctive service and support needs?

Question 2: What does the research tell us about interventions targeted at specific groups and about the effectiveness of these interventions?

This report distinguishes the particular support and service needs of victims of institutional child sexual abuse and how these needs may differ from victims of non-institutional child sexual abuse. In addition, it examines whether factors such as context, duration and perpetrator influence the nature and extent of longer-term effects on survivors.

The literature presented relates specifically to services and support provided to three select population groups:

- people who have experienced child sexual abuse in an institutional context
- Aboriginal and Torres Strait Islander people
- people with disability.

The first group is of primary interest to the Royal Commission, while the latter two groups have been included because of their increased vulnerability to child sexual abuse compared with the general population, their long history of institutionalisation carried out as accepted government policy, and their continued over-representation in various forms of institutional care. However, it is important to note that the research on institutional child sexual abuse does not always distinguish between these population groups, and victims could potentially be at the intersection of all three.

Methodology

The research team conducted a literature review of published studies relevant to the research aims and key research questions. To do this the research team implemented an analytic process, termed 'thematic synthesis', which is useful for analysing qualitative data alongside quantitative data synthesis.

Combinations of search terms organised into three conceptual areas identified resources from academic databases and government and non-government websites for possible

inclusion in the review. The research team considered both peer-reviewed research and grey literature, including Australian and international empirical studies and select theoretical research that met the eligibility criteria. Sampling for this literature review was deliberative and based on agreed inclusion and exclusion criteria. Data from relevant studies meeting the agreed inclusion criteria were then extracted and results from this extraction were collected, with select thematic data synthesised for presentation in this literature review. The project team assessed the quality and relevance of studies for the evidence review using criteria adapted from the Critical Appraisal Skills Programme (CASP) checklist. In addition, care has been taken when drawing conclusions about the 'evidence' and when interpreting or comparing research findings, to ensure that any comparison made is meaningful and reflects a rigorous analytic process.

Support needs of specific population groups affected by child sexual abuse in institutional contexts

Population Group 1 – People who have experienced child sexual abuse in an institutional context

It is important to distinguish between different types of institutions. One clear line of distinction is between 'closed' institutional systems, such as residential out-of-home care, and 'open' systems, such as sports clubs and day-care centres. In a closed system, a child's life is strictly controlled by a single authority and its delegates. The child may have little contact with people outside the institution, and few stable attachment relationships that provide support, foster resilience and allow for the safe disclosure of adverse events such as child sexual abuse. In contrast, a child's contact with an open system is just one component of his or her life. The child potentially has secure attachments outside the institutional context, and it is easier for the child to sever ties with the institution.

However, despite the recent focus on child sexual abuse perpetrated in institutional contexts, the prevalence of child sexual abuse in institutions remains unknown. Key factors affecting victim disclosure relate to the significance of the institution in society; the role of the perpetrator in that institution; the perpetrator's reputation and status in the wider community; and, for boys and adult males, fear of stigmatisation and the prevalence of homophobia. Fear, guilt and shame, as well as intimidation by the perpetrator, also affect disclosure. These factors may lead victims to fear that they will not be believed or that they are at fault.

In contrast to the scarcity of research on the *prevalence* of child sexual abuse in an institutional context, there is a growing body of evidence that explores the *effects* on victims and survivors of child sexual abuse in an institutional context. A number of factors have been identified as contributing to longer-term effects. These include sexual abuse that begins before age 16, abuse that goes undisclosed and untreated for extended periods of time, abuse that is frequent and severe, abuse perpetrated by a parent or parental figure and lack of social support in response to disclosure of abuse.

Distinctive dimensions of the harm suffered by child sexual abuse victims that may relate to the institutional context in which they experienced their abuse include:

- a global loss of trust that may extend to other institutions sanctioned by society, exacerbated by lack of preventative and remedial measures taken by the institution
- a crisis of faith, or abandonment of religion, if the abuse was clergy-perpetrated
- ostracism by other members of the community who are involved with the institution
- in some cases, further victimisation that stems from a rallying of support for the perpetrator
- a fear of, and/or disrespect for, authority.

There is emerging evidence that the particular context and dynamics of institutional child sexual abuse may affect the types of treatment and support needed. While scant, the evidence suggests that treatment and support needs vary, depending on whether the child sexual abuse was experienced in a residential institutional context or a non-residential institutional setting. There is limited empirical evidence on the effectiveness of particular supports or treatments for people who have experienced child sexual abuse in an institutional context. However, qualitative studies with survivors of child sexual abuse in residential institutions point to the value of long-term, specialist psychological support, but many survivors have not been able to receive these services. In the context of child sexual abuse in non-residential institutions, such as day-care centres, there is evidence of a strong link between the functioning of victims and their parents and families, suggesting that clinicians should ensure their treatment encompasses the family, not just the individual victim. For clergy-perpetrated child sexual abuse, research points to the need for treatments to consider the effect of the sexual abuse on the survivor's spiritual beliefs and practice.

Population Group 2 – Service and support needs of Aboriginal and Torres Strait Islander people

There is consensus in the literature that sexual abuse of Aboriginal and Torres Strait Islander children must be viewed in the context of the historical legacy of colonisation, racism, deprivation, forced removal of children from their families and ensuing intergenerational trauma. Linked to this history are a range of factors that increase the vulnerability of Aboriginal and Torres Strait Islander children. These include higher rates of exposure to domestic and family violence and alcohol abuse than non-Aboriginal and Torres Strait Islander children; the tendency of their communities to have a younger age demographic than non-Aboriginal and Torres Strait Islander population creating implications for children and young people through the availability of care; and the ongoing socio-economic disadvantage experienced by a substantial number of Aboriginal and Torres Strait Islander people and communities.

The literature strongly argues that services and supports for Aboriginal and Torres Strait Islander people who have experienced child sexual abuse should be based on recognition of

the central importance of extended family and community relationships. Research points to a range of factors that may lead to more effective support services for Aboriginal and Torres Strait Islander people who have experienced child sexual abuse, such as:

- enhancing support workers' understanding of, and engagement with, the complex histories, cultures and contemporary social dynamics of Aboriginal and Torres Strait Islander populations
- giving victims the option of seeing an Aboriginal and Torres Strait Islander support worker if preferred
- recognising the interconnectedness of individuals
- acknowledging the importance of extended family and community in the lives of Aboriginal and Torres Strait Islander people
- partnering with Aboriginal and Torres Strait Islander communities to develop and deliver child sexual abuse support services.

There is also an increasing focus in the literature on healing programs for Aboriginal and Torres Strait Islander child sexual abuse victims and their families and communities. Evaluation of healing programs is still at a formative stage. It is unclear how effective these programs are for the victims, as many child sexual abuse-related healing programs have a restorative justice focus and do not appear to provide therapeutic support for victims or survivors. In addition, these programs do not always distinguish between Aboriginal and Torres Strait Islander survivors of intra-familial child sexual abuse and institutional abuse. The research team located only one peer-reviewed evaluation of an intervention to support Aboriginal peoples who have experienced child sexual abuse. This evaluated a program in Canada and had a range of methodological limitations. Two qualitative evaluations of government initiatives to improve responses to child sexual abuse in Aboriginal and Torres Strait Islander communities in Australia are also summarised, although these programs have a broader focus than just therapeutic support for victims.

Population Group 3 – Service and support needs of people with disability

The literature clearly demonstrates that children with disability experience higher rates of sexual abuse, and are at greater risk of sexual violence, than children without disability. There is also emerging evidence that a greater proportion of sexually abused children with disability experience 'serious' sexual abuse (for example, penetration) compared to sexually abused children without disability. Additional factors make the disclosure and reporting of child sexual abuse less likely when the victim has a disability. Depending on the nature of the disability, these factors include difficulty communicating; lack of understanding or identification of abuse due to cognitive impairment; reliance on personal care; and fear that disability support services will be removed.

There is very little empirical, peer-reviewed literature on treatments or interventions for people with disability who were sexually abused as children. Additionally, the research team

could find no evidence of controlled trials of such treatment or interventions. Research supports the view that it is possible to adapt verbal and non-verbal therapies for people with intellectual disability, including psychodynamic, behavioural, cognitive and other techniques; although there are no treatment studies that clearly establish efficacy. There is also some evidence that group therapy may be particularly useful for people with intellectual disability who have experienced sexual abuse, as a way of developing socio-sexual understanding, promoting social interaction and reducing isolation. Yet there is evidence of a competing view shared among other mental health clinicians that people with intellectual disability are unsuited to traditional insight-oriented therapies. This is linked to their limited language and abstract-conceptual abilities. This view may have hindered the development of more appropriately targeted treatment approaches.

People with disability report that it is rare for them to receive therapy specifically adapted to their needs. In addition, there are indications that as a cohort they may fall between 'disciplinary gaps' where clinicians are either disability or sexual assault specialists but may not have the required knowledge of this cohort's intersecting needs. There is also a concern that services may be 'referring on' so that people with disability are caught in a cycle of successive referrals without receiving support, with the eventual result that some victims no longer seek help from services.

Summary

Overall, this literature review highlights the importance of further research to better understand the treatment needs of particular population groups of victims/survivors of institutional child sexual abuse. It is not possible to develop one best-practice response that will appropriately address the needs of different cohorts, although the literature does helpfully identify some common factors for the consideration of policymakers and clinicians. This gap in the evidence base remains a challenge despite the promising practices that are starting to emerge.

INTRODUCTION

Child sexual abuse is a complex phenomenon. Evidence confirms that despite widespread notions of ‘stranger danger’, child sexual abuse is almost always perpetrated by someone known to the child. This includes immediate and extended family members, as well as family friends and other trusted adults. Moreover, as demonstrated by testimony at the Royal Commission, children from a range of institutional contexts – encompassing programs or services of any kind in which adults have contact with or are in some way responsible for children – have experienced sexual abuse.

There is a body of literature examining support services for child and adult victims/survivors of childhood sexual abuse in general, but there is much less research on responses to institutional child sexual abuse. This includes research into services that directly address the distinct challenges of dealing with abuse in institutional contexts, as well as in certain population groups such as Aboriginal and Torres Strait Islander communities and among individuals with disability.

The Royal Commission was established in January 2013 to inquire into and report on responses by Australian institutions to instances and allegations of institutional child sexual abuse. Following an extensive program of submissions, hearings and research projects, the Royal Commission will make recommendations to improve laws, policies and practices in Australian public and private institutions to prevent and better respond to child sexual abuse.

The Royal Commission is implementing a comprehensive research program to support its work and address the Terms of Reference. The sixth theme of the research program relates to the treatment and support needs of victims/survivors and their families.

In recognition of the perceived lack of evidence available to inform responses to specific population groups, the Royal Commission engaged researchers from the GVRN to undertake a review of literature on the support needs of specific population groups affected by institutional child sexual abuse.

Two core questions were agreed with the Royal Commission to comprehensively address the focus of the literature review:

Question 1: Do different groups of survivors have distinctive service and support needs?

Question 2: What does the research tell us about interventions targeted at specific groups and about the effectiveness of these interventions?

This report distinguishes between the particular support and service needs of victims from different institutional contexts and how these may differ from other victims of child sexual abuse. In addition, it examines whether factors such as context, duration and perpetrator influence the nature and extent of longer-term effects on survivors.

The structure and scope of this report

This review considers literature relating to effective services and support for three population groups:

- people who have experienced child sexual abuse in an institutional context
- Aboriginal and Torres Strait Islander people
- people with disability.

The first group is of primary interest to the Royal Commission. The latter two groups have been included because of their increased vulnerability to child sexual abuse compared with the general population; their heightened contact (historical and ongoing) with institutional systems; and the distinctive factors that affect their support needs. Evidence will be presented in relation to each cohort, responding to the two defining research questions and related sub-questions, all of which have informed the search strategy.

The structure of this report and the research questions were developed in consultation with the Royal Commission.

Methodology

The research team reviewed literature from published studies considered relevant to the research aims and key research questions, including peer-reviewed articles, grey literature and websites. The team implemented an analytic process that Mays et al. (2005) termed 'thematic synthesis', as it is useful for analysing qualitative data alongside quantitative data synthesis. The purpose of using a systematic approach for a synthesis review of data from diverse methodological traditions is to enhance the confidence of policymakers and service providers to act on the team's findings.

Identifying key research questions

The Royal Commission developed the key research questions for this study. Additional sub-questions were developed to further inform the search strategy. This is summarised in Table 1.

Table 1 Research questions

Key research questions	<ol style="list-style-type: none"> 1. Do different groups of survivors have distinctive service and support needs? 2. What does the research tell us about interventions targeted at specific groups and about the effectiveness of these interventions?
Related sub-questions	<ul style="list-style-type: none"> • How do the service and support needs of different population groups (such as Aboriginal and Torres Strait Islander people and people with disability) differ from other victims of child sexual abuse?
	<ul style="list-style-type: none"> • What evidence is there regarding particular service and support needs for victims of child sexual abuse in an institutional context?
	<ul style="list-style-type: none"> • How do these needs differ depending on the type of institutional abuse, considering such factors as the context and duration of the abuse, and the perpetrator?

Databases and repositories searched

The research team searched Australian and international empirical studies, as well as select theoretical research, on academic databases and government and non-government websites. Both peer-reviewed research and grey literature that met the eligibility criteria were considered. A detailed outline of the search strategy used for this review is included in Appendix One. The following databases were searched on the EBSCO, Informit and ProQuest platforms:

- EBSCO: Family & Society Studies Worldwide; Family Studies Abstracts; Violence and Abuse Abstracts
- Informit: Australian Public Affairs Full Text; Australian Public Affairs Information Service; Aboriginal and Torres Strait Islander Health Bibliography; Australian Family & Society Abstracts Database (and Aboriginal and Torres Strait Islander collection); Families & Society Collection; Health & Society Database; Humanities & Social Sciences Collection
- ProQuest: Applied Social Sciences Index and Abstracts (ASSIA); International Bibliography of the Social Sciences (IBSS); PILOTS: Published International Literature On Traumatic Stress; Family Health Database; ProQuest Health & Medical Complete; ProQuest Nursing & Allied Health Source; ProQuest Social Science

Journals; ProQuest Sociology; Social Services Abstracts; Sociological Abstracts.

In addition to quantitative studies, the research team reviewed refereed papers, reports and select book chapters examining qualitative evidence on workers' and survivors' self-reported experiences of available services and supports. Qualitative evidence is an important complement to the quantitative research in this field, and provides significant insight into the help-seeking experiences of victims and survivors of child sexual abuse, as well as their perceptions of the helpfulness of service responses. Qualitative evidence is also important given the scarcity of quantitative outcome evaluations in some areas, such as services for Aboriginal and Torres Strait Islander people or people with disability who have experienced child sexual abuse.

The research team searched for grey literature on the following websites:

- Adults Surviving Child Abuse (now Blue Knot): www.asca.org.au
- Australian Institute of Family Studies library: www.aifs.gov.au
- Australian National Research Organisation for Women's Safety: www.anrows.org.au
- Child Family Community Australia: www3.aifs.gov.au/cfca/
- Closing the gap clearinghouse: www.aihw.gov.au/closingthegap/
- FaithTrust Institute: www.faithtrustinstitute.org
- Mental Health Coordinating Council: www.mhcc.org.au
- Minister and Clergy Sexual Abuse Survivors: www.macsas.org.uk
- Respond SA: www.respondsa.org.au
- Secretariat of National Aboriginal and Islander Child Care: www.snaicc.org.au
- Sexual Violence Research (formerly Australian Centre for the Study of Sexual Assault): www.aifs.gov.au/acssa/
- Survivors Network of Those Abused by Priests: www.snapnetwork.org
- UNICEF: www.unicef.org.au
- World Health Organization: www.who.int

Database search terms

Search terms were chosen and organised into three conceptual categories designed to address the defining research questions. Combinations of the terms from the three categories were entered in the specified databases. Search terms are presented in detail in Appendix One.

Selecting relevant studies

Sampling for this literature review was deliberative and includes all references available that meet the broad inclusion criteria. Studies for this review were selected based on the following exclusion and inclusion criteria, which were agreed with the Royal Commission.

Exclusion criteria:

- The type of child abuse is not defined (that is, sexual, physical and emotional abuse and neglect are not, or cannot be, differentiated in the results).
- The abuse studied is of a non-sexual nature only (that is, physical or emotional abuse, or neglect, but not sexual abuse).
- The particular types of services or support received by victims are not specified in sufficient detail.
- The definition of sexual abuse does not match the Royal Commission's definition.
- The sample group/population comes from a country that is not part of the Organisation for Economic Co-operation and Development (OECD)
- The study report and findings were not written in English.
- The study focuses on individual case studies only.
- The study focuses on legal support services for victims.

Inclusion criteria:

- The study focused on child sexual abuse, or child sexual abuse is separately delineated in the results.
- The definition of child sexual abuse aligns with that of the Royal Commission.
- The sexual abuse is of any duration, any frequency and any severity.
- The victim was aged under 18 when the abuse took place.
- The sexual abuse occurred in any context, institutional or otherwise.
- The sample group comes from Australia or another OECD country.
- The focus is on therapeutic interventions, responses and supports.

Synthesising, summarising and reporting on findings

The project team assessed the quality and relevance of studies and articles included in this literature review using criteria adapted from the Critical Appraisal Skills Programme (CASP)¹ checklist. The CASP checklist and tools are intended to provide a systematic process to identify and appraise evidence for trustworthiness and relevance to the research questions. The advantage of CASP is that it is designed to help practitioners and policymakers make sense of evidence and assess its worth with the explicit aim of enhancing interventions and policy development in their given area. The quality of studies included in the review has been informally appraised using criteria based on the CASP checklist.

¹ See www.casp-uk.net

There are three main analytic phases in the CASP checklist:

1. **Is the study valid?** Assessing the methodological quality of the article, chapter, review or evaluation.
2. **What are the results?** Considering whether the reported results are clinically² important and whether there is any uncertainty about the results.
3. **Are the results useful?** Examining if and how the results apply to the research questions in an explicit, transparent way.

Selected data from studies meeting the inclusion criteria were thematically synthesised for presentation in this literature review.

Methodological issues relating to child sexual abuse research

At the start of this literature review, three key factors were identified for careful consideration when examining the evidence documenting the availability, modality and effectiveness of support services to victims and survivors of child sexual abuse. These factors are:

- definitional differences in the research literature
- specific issues inherent in the examination of 'sensitive' topics
- methodological and ethical issues particular to child sexual abuse research.

Definitions in the research literature

It is important to note that definitions of child sexual abuse, as well as definitions of different therapeutic modalities and interventions, may not be universally agreed upon among researchers. Moreover, some studies do not adequately define core concepts, with the result that different research outcomes are not always directly comparable.

Other points of definitional difference include:

- The age of consent and the age at which childhood is deemed to end vary between jurisdictions and across cultural groups, which means there is no single agreed age of consent.
- Studies frequently do not differentiate between incest (intra-familial abuse) and extra-familial child sexual abuse, or where victims have been abused in institutional contexts.
- Some studies do not differentiate between types of child abuse; therefore incidents of child sexual abuse are subsumed under the generic 'child abuse' or 'child protection' categories.

² The term 'clinically' is used very broadly here to include direct practice and programming. The use of the term reflects the history of the methodology, and so it has been used to be consistent.

Alongside these points, many victims also report a co-occurrence of physical abuse, neglect and domestic violence – all of which may be the subject of research. Therefore, it can be difficult to distinguish the effectiveness of interventions provided in relation to the child sexual abuse alone rather than as a response to the combined presenting problems.

Specific issues relating to sensitive topics

In addition to definitional limitations, research on sensitive topics such as child sexual abuse is subject to a number of methodological and ethical complexities:

- *The capacity for specific populations and cohorts to distort the overall picture:* Empirical research into hidden or illegal phenomena such as child sexual abuse often draws on participants from clinical or criminal justice contexts. While these studies contribute to the emerging evidence base, they rely on very particular cohorts and therefore may not represent the experiences of perpetrators and victims in the general population more broadly.
- *Substantial research indicates that child sexual abuse is under-reported:* Only a small proportion of children disclose sexual abuse in childhood because of guilt, shame and fear of reprisal. Adult survivors also rarely disclose, and if they do they tend to disclose to friends and family networks rather than professionals, effectively limiting our understanding of this sample group. Moreover, little is known of the experiences of those survivors who have chosen not to formally disclose or the strategies they may have used to ‘recover’ at the time or in the longer term.
- *Evidence suggests that specific population groups frequently do not access services for child sexual abuse:* As most studies rely on participants drawn from services responding to victims/survivors, the experiences of individuals with disabilities, Aboriginal and Torres Strait Islander peoples, those from culturally and linguistically diverse communities, refugees and those abused in institutional settings are under-represented in research studies.

Individually and when taken together, these issues explain why only the experiences of certain victims/survivors are represented in research findings.

Methodological and ethical issues particular to child sexual abuse research

A number of methodological issues affect research on child sexual abuse (see Cashmore and Shackel, 2013) in particular ways:

- The number of outcome studies of child sexual abuse treatment programs is limited.
- Outcome studies of child sexual abuse treatment programs frequently fail to distinguish whether sexual abuse occurred in an institutional or non-institutional context (or both).
- The different conceptual approaches in the therapeutic interventions studied (for

example, trauma-informed interventions, cognitive therapy and family therapy) limit comparability between studies.

- Establishing 'effectiveness' from a research perspective requires the inclusion of a control group that does not receive the treatment being studied. Denying survivors a potentially helpful service raises clear ethical concerns.
- The ethical and implementation difficulties involved in randomised control trials in this area of research make it difficult to establish whether outcomes following disclosure can be directly linked with professional intervention, or with changed life circumstances or a combination of both.
- Findings from studies of specific sample populations cannot necessarily be generalised for the population of child sexual abuse victims as a whole.

SERVICE AND SUPPORT NEEDS OF SPECIFIC POPULATION GROUPS

To explore the service and support needs of the three population groups identified, the report presents evidence that considers how the needs of population groups differ from others (research question 1); and what the research tells us about interventions targeted at specific groups and their effectiveness (research question 2). The report also distinguishes between the particular support and service needs of victims from different institutional contexts and how these may differ from other victims of child sexual abuse. In addition, it examines whether factors such as context, duration and perpetrator influence the nature and extent of longer-term effects on survivors.

Population Group 1 – People who have experienced sexual abuse in an institutional context

We have used the definition of ‘institution’ as set out in the Terms of Reference, summarised in the Royal Commission’s *Interim Report: Volume 1* (2014) as ‘any public or private body, agency, association, club, organisation or other entity that is, or was in the past, involved with children’ (p 101).

As this is a broad definition, it is useful to distinguish between different types of institutions. One clear line of distinction is between ‘closed’ institutional systems, such as residential out-of-home care (and orphanages in the past), and ‘open’ systems, such as sports clubs or day-care centres (Sprober et al. 2014). In a closed system, a child’s life in the institution is strictly controlled by a single authority and its delegates. The child may have very little contact with people outside the institution, and may have fewer stable attachment relationships that provide support, foster resilience and allow for safe disclosure of adverse events such as child sexual abuse. In contrast, in an open system the child’s contact with the institution is just one component of his or her life, the child potentially has secure attachments outside the institutional context, and it is easier for the child to sever ties with the institution. Both closed and open systems pose risks for abuse of children, and child sexual abuse in both types of institutions is characterised by ‘exploitation of the hierarchic structures of power and dependence that typically define the relationship between youth and their caregivers’ (Sprober et al. 2014: 293)

The prevalence of child sexual abuse in institutions remains unknown (Sprober et al. 2014), and the Royal Commission notes in its *Interim Report* that to understand the prevalence of abuse perpetrated in these circumstances it is collating data from the police, child protection agencies, education departments and other bodies (Royal Commission into Institutional Responses to Child Sexual Abuse 2014: 6).

Disclosure of institutional child sexual abuse

Like disclosure of child sexual abuse generally, disclosure of child sexual abuse in an institutional context usually occurs many years after the abuse has ceased. The John Jay College Research Team found that only one in four allegations of child sexual abuse by clergy members was made within 10 years of the abuse. It found that half of all allegations were made between 10 and 30 years after the abuse, and the remaining one-quarter were reported more than 30 years after the abuse.

Easton's 2013 study of 487 adult male survivors of child sexual abuse included a high proportion of survivors of clergy abuse (62 per cent) and found that:

- they delayed disclosure of child sexual abuse by an average of 21 years
- seventy-seven per cent had participated in an in-depth discussion of the abuse, but on average this occurred 28 years later
- the percentage who reported child sexual abuse to authorities was higher for survivors of clergy abuse (20 per cent) than for other survivors (8 per cent); this result was statistically significant
- survivors of intra-familial abuse were less likely than other survivors to notify authorities and to disclose in childhood, and took longer to tell someone about the abuse (statistically significant findings).

These findings suggest that survivors of clergy abuse were more likely to disclose to authorities than other survivors of child sexual abuse. In particular, the research suggests that the identity of the perpetrator and their relationship to the victim contributes to the longer-term effects of child sexual abuse.

Wolfe et al. (2003) found that key factors inhibiting disclosure for people who experience institutional abuse relate to the significance of the institution in society and the role of the perpetrator in that institution. These factors may lead victims to fear that they will not be believed or that they are at fault (see section below for further details of the conceptual framework for institutional abuse devised by Wolfe et al.). Additional factors that may affect disclosure of institutional child sexual abuse include:

- for male victims, issues relating to male socialisation, which teaches boys that 'to be a victim is not masculine' (Isely and Isely 1990: 88)
- fear of stigmatisation, given the prevalence of homophobia (Isely and Isely 1990)
- the wider community's reverence and respect for the perpetrator, who is viewed as a representative of God (Isely et al. 2008)
- fear, guilt and shame, as well as intimidation by the perpetrator (Fater and Mullaney 2000).

In the context of the sexual abuse of children in state care in South Australia, survivors giving evidence at the 2008 Mullighan Inquiry said they did not disclose abuse because:

- 'the same thing had happened at home previously anyway' (2008: 388)
- the power imbalance, as many of the perpetrators were in authority or associates of those in authority
- the violence and intimidation that was synonymous with state care, where efforts to resist sexual abuse often resulted in physical violence or enforced, arduous physical activity as a form of psychological intimidation and punishment
- a culture that punished disclosure of child sexual abuse
- frequent transfers between placements, making it difficult to forge trusting relationships, therefore minimising opportunities for disclosure
- a sense of isolation, and limited, brief contact with departmental welfare workers.

However, it is important to note that some of the factors affecting disclosure of child sexual abuse in an institutional context are also reported by victims of sexual abuse in their immediate or extended family or social network.

Reported impacts of institutional child sexual abuse

Sexually abused children as a group, regardless of whether or not the perpetrator is a family member, exhibit psychological problems for which they may benefit from professional intervention, either as children (Ligezinska et al. 1996) or later as adults (Breckenridge et al. 2008). An overview of the research in this area by Ligezinska et al. notes that children who have experienced extra-familial sexual abuse (which may or may not have occurred in an institutional context) can show symptoms of post-traumatic stress disorder (PTSD) and exacerbated fears, anxiety, sexual problems, difficulty in social interactions, depression and low self-esteem. These symptoms may be present even with less severe forms of sexual abuse (Ligezinska et al. 1996). In contrast to the scarcity of research on the *prevalence* of child sexual abuse in an institutional context, there is a growing body of evidence that explores the *effects* on victims and survivors of child sexual abuse in an institutional context.

Religious residential institutions

Studies of people who lived in religious residential institutions have found that more than 80 per cent of survivors of institutional abuse (physical, emotional or sexual) experience high rates of adult mental health problems. These include PTSD, alcohol and substance abuse, mood-related disorders, anxiety and anti-social personality disorder (Carr et al. 2010; Fitzpatrick et al. 2010; Wolfe, Francis and Straatman 2006). In addition, higher rates of mental health problems are found in survivors of severe sexual abuse in religious residential institutions, compared with survivors of severe physical or emotional abuse in other institutions (Fitzpatrick et al. 2010). Sexual abuse of children who lived in religious institutions has also been associated with current post-traumatic stress symptoms and major life problems (Commission to Inquire into Child Abuse 2009: vol 5, p 97).

Secular residential institutions

A recent German study suggests that child sexual abuse is not limited to religious residential institutions. The study found that psychiatric disorders relating to experiences of child sexual abuse occur with equal frequency and severity in secular residential institutions. A 2014 study by Sprober et al. of 1,050 survivors of child sexual abuse who lived in both religious (Catholic and Protestant) and secular institutions in Germany, found similar rates of psychiatric disorders across both religious and secular institutions: 80, 79 and 74 per cent for those from Catholic, Protestant and secular institutions respectively. The most common diagnoses for survivors of child sexual abuse in all institutions was depression, followed by PTSD (Catholic and secular institutions) and anxiety/obsessive compulsive disorder (Protestant institutions).

Non-residential institutional settings (day-care centres)

There is also evidence of the mental health impacts of child sexual abuse on victims in non-residential institutional settings, such as day-care centres. While this evidence is dated, studies suggest that those abused at day-care centres showed significantly more depression, social withdrawal, somatic complaints, schizoid obsessive thoughts, aggression and more problems with sexuality (with behaviours scoring in the clinical range) than a local comparison group of matching age and sex (Mowbray and Bybee 1995). The victims from day-care centres met the diagnostic criteria for PTSD in nine out of 10 cases (Kiser et al. 1991) and demonstrated significantly more behavioural disturbances and significantly lower social competence than non-abused children (Kelley cited in Reyman 1990).

Importantly, institutional sexual abuse in a non-residential context (such as a day-care centre) can have a psychological impact on the victim's family (Reyman 1990). One later study showed parents can continue to suffer symptoms of PTSD four years after their child was abused (Dyb et al. 2003). Another study found that parents' (especially mothers') emotional functioning scores after their disclosed child sexual abuse fell within the clinical range (Manion et al. 1998 – note that this study relates to extra-familial abuse more broadly, not necessarily in an institutional context).

Clergy-perpetrated child sexual abuse

There is evidence of PTSD symptoms in survivors of clergy-perpetrated abuse, in combination with other symptoms such as self-blame, guilt, psycho-sexual disturbances, self-destructive behaviours and substance abuse. It has been suggested that this symptom profile is better captured by the 'complex PTSD' construct proposed by Herman (1992). According to Fogler et al. (2008: 335–36), the literature strongly suggests that several of the factors known to contribute to chronic psychiatric symptoms, including PTSD, may be present in children and adolescents who are sexually abused by clergy members. These include sexual abuse that begins before age 16, abuse that goes undisclosed and untreated

for extended periods, abuse that is frequent and severe, abuse perpetrated by a parent or parental figure and lack of social support in response to disclosure of abuse.

Are there distinctive features of child sexual abuse in an institutional context?

The literature suggests institutional child sexual abuse has certain distinctive characteristics that may vary depending on the particular institutional setting. Moreover, these characteristics may contribute to the harm experienced by victims and survivors and are therefore important considerations in terms of providing support and treatment for victims.

Wolfe et al. (2003) developed a conceptual framework of the factors that may contribute to harm experienced by victims of child sexual abuse in institutional contexts. This framework distinguishes institutional child sexual abuse from cases of intra-familial abuse and from non-institutional extra-familial child sexual abuse. The components of this conceptual framework are:

- **The significance and role of the institution in society:** When the institution is highly valued and held in high esteem by the community, disclosure of child sexual abuse may be more difficult. The victim's decision about whether to disclose the child sexual abuse and the responses to the disclosure will both be influenced by community support for the institution, the public nature of the institution and public scrutiny of the events and the power and resources of the institution itself.
- **The role of the perpetrator in the institution:** Where a perpetrator holds a position of authority in an institution (and, by extension, in the wider community), victims of child sexual abuse may feel less able to disclose the abuse due to fear that they will not be believed; they are at fault; they will lose the perpetrator's favour; they will be unfairly denied opportunities for advancement (for example, in a sports team); or the perpetrator will in other ways make their life difficult.
- **The victim's involvement with the institution:** Children who have a mandatory involvement with the institution may feel powerless to escape, or may believe that whatever happens at the institution is 'normal'.
- **Abuse and post-abuse events:** These factors include whether the account of the victim or of the perpetrator is believed; the potential for loss of community support, deepening isolation from and vilification by the community; and unhelpful responses by the institutional hierarchy to disclosure of child sexual abuse.

Wolfe et al. (2003) also considered distinctive dimensions of the harm suffered by child sexual abuse victims that may relate to the institutional context in which they experienced the abuse. These include:

- a global loss of trust that may extend to other institutions sanctioned by society, and exacerbated by a lack of preventative and remedial measures taken by the institution
- a crisis of faith, or abandonment of religion, if the abuse was clergy-perpetrated (see

also Fater and Mullaney 2000; Isely and Isely 1990)

- ostracism by other members of the community who are involved with the institution
- in some cases, further victimisation that stems from a rallying of support for the perpetrator
- a fear of, or disrespect for, authority.

Responding further to research question 1, a range of distinctive attributes of child sexual abuse perpetrated in an institutional context emerged from analysis of other research in the field and are summarised below.

Residential institutions and other out-of-home care

Research by Sprober et al. (2014) suggests that certain factors common to all residential institutions – religious and secular – can affect victims of child sexual abuse. These include group cohesion (among those in control), hierarchical power structures and the dependence of child residents. These factors are conducive to repeated, ongoing, sexual abuse. Other factors common to residential institutions, as mentioned in the study by Sprober et al., include the duration of the sexual abuse and the response of institutional authorities to disclosure. More than 90 per cent of survivors (n = 1,050) of sexual abuse in religious and secular institutions stated that the abuse had been ongoing. In addition, many said they were ignored or even punished when they reported the abuse to authorities.

Additional factors that may increase the risk of child sexual abuse in out-of-home care, including foster care, are frequent placement transitions, the non-biological relationship between child and caregiver, and experiences of abuse before entering out-of-home care. In residential care (as opposed to foster care), these risks are elevated due to larger child-to-caregiver ratios, cohabitation of large numbers of vulnerable peers of both sexes, and high peer and staff turnover (Euser et al. 2013). There is also evidence that children who have experienced intra-familial child sexual abuse before they enter out-of-home care are more likely to have unsuccessful foster placements. They are also less likely to use adaptive coping strategies than children in out-of-home care who do not have a prior history of child sexual abuse (Browne 2002).

Non-residential institutions

Much of the research on this topic relates to extra-familial abuse more broadly, so while it may be known that the abuse was not perpetrated by a family member, it is unclear whether it occurred in an institutional context. However, an important finding from the literature is that extra-familial child sexual abuse is a traumatic stressor for parents as well as the child victim, and the trauma experienced by the victim is shared by the parents (Grosz, Kempe and Kelly 2000; Manion et al. 1998). Research on extra-familial child sexual abuse in an institutional context (such as in day-care centres) supports this finding (Dyb et al. 2003; Kiser et al. 1991). In addition, Kiser et al. noted that parents struggled with feelings of guilt,

betrayal, depression and anger, and believed their responses to the abuse affected their parenting ability.

In other respects, the literature on extra-familial abuse in non-residential institutions is not particularly helpful in identifying distinctive characteristics of institutional abuse. This is because much of the research concerns extra-familial child sexual abuse that is not institutional (perpetrated by neighbours, family friends or babysitters, for example). This literature suggests that victims of extra-familial child sexual abuse were on average older than intra-familial victims; were more often subject to physical and verbal force and enticement; experienced abuse that was generally of shorter duration; and suffered less emotional and psychological injury (Fischer and McDonald 1998; Magalhães et al. 2009; DiLillo, Long and Russell 1994).

In contrast, research into extra-familial abuse in an institutional context has found that institutional abuse is generally ongoing rather than an isolated incident (Wolfe et al. 2003). In the study by Sprober et al., more than 90 per cent of child sexual abuse survivors from residential institutions stated that the abuse had been ongoing. In addition, in a study of trauma and family functioning among 100 adolescent victims of intra- or extra-familial child sexual abuse in Belgium (where at least 21 per cent of the extra-familial sexual abuse was perpetrated by teachers or priests in an institutional context), there were no significant differences in symptoms between victims of extra-familial or intra-familial abuse (Bal et al. 2004).

It is also worth noting the finding that specific family factors were more associated with intra-familial abuse than extra-familial abuse: divorce, drug abuse by the father and overall lower socio-economic status (Bal et al. 2004).

Another distinctive feature of non-residential institutional child sexual abuse is the potential for the abuse to affect an entire community, as in the case of child sexual abuse at a day-care centre or within a religious community. These cases can attract much public and media attention, adding another stressor for victims and their families (Dyb et al. 2003), and also distinguishing the experience from that of victims of non-institutional child sexual abuse.

Clergy-perpetrated child sexual abuse

Research suggests a number of distinctive factors are associated with clergy-perpetrated child sexual abuse:

- Perpetrators manipulate victims into feeling they are being 'silenced by God' (Fogler et al. 2008; Isely et al. 2008).
- The religious community is involved in the dynamic interaction between perpetrator and victim/survivor around the abuse (Fogler et al. 2008).

- The wider community's reverence and respect for the perpetrator, who is viewed as a representative of God, may influence a victim's decision about disclosing the abuse (Isely et al. 2008; Wolfe et al. 2003).
- The idiosyncratic trauma characteristics of survivors involve theological, spiritual and existential symptomatology (Fogler et al. 2008, citing Farrell and Taylor).
- Child sexual abuse survivors disengage from religious and spiritual activities (Fater and Mullaney 2000; Isely et al. 2008).

The literature indicates that in clergy-perpetrated child sexual abuse, the public stature of the perpetrator affects disclosure and can contribute to a very particular dynamic affecting both the symptoms and longer-term effects experienced by victims.

Support and treatment for people who experience child sexual abuse in an institutional context

There is very little empirical evidence on the effectiveness of different types of support and treatment for people who have experienced child sexual abuse in an institutional context. This may reflect a lack of specific services and treatment for this cohort of survivors until very recently. Given the difficulties relating to disclosure that victims of institutional sexual abuse may have experienced as children, much of the literature on support and treatment comes from retrospective qualitative studies of adult survivors. The relevant findings are summarised in the sections below.

Residential institutions

A qualitative study of 24 survivors of child sexual abuse in residential institutions in the UK (Colton, Vanstone and Walby 2002) found that most survivors felt that highly skilled, long-term counselling and psychiatric help were especially valuable, but not all had been able to receive such help. Several survivors spoke of the usefulness of self-help groups and believed these groups offered the most effective form of help. The authors also found that allowing survivors' access to official information from their childhood, including records relating to their abuse, may be an important part of the recovery process. One survivor stated that a special centre should be established to help survivors and their families.

More than 80 per cent of survivors of abuse in residential institutions experience psychological disorders, and victims of severe sexual abuse experience higher rates of mental health problems. Given this, Carr et al. (2010) concluded that it is essential that evidence-based psychological treatment be made available to survivors. In addition, they said clinicians should be trained in treating issues typically affecting survivors, including anxiety, mood and personality disorders, trauma symptoms, adult attachment problems and substance abuse.

In South Australia, submissions to the Commission of Inquiry into Children in State Care emphasised the inadequacy of therapeutic services for survivors of child sexual abuse.

Submissions supported the establishment of a specialist counselling service for adult survivors of child sexual abuse in state care, which the Commission recommended (Mullighan 2008: 446). Similar evidence was submitted to the Senate committee investigating experiences of Australians in institutional care as children (Senate Community Affairs References Committee 2004), and centred around the need for counselling that is ongoing (not short term), specialist (where clinicians have an understanding of the issue faced by people leaving institutions and who have experienced abuse), and provided by organisations that are independent of the churches that ran the institutions where survivors suffered abuse.

Non-residential institutions

The literature on treatment of extra-familial child sexual abuse suggests there is a strong link between the functioning of victims of extra-familial child sexual abuse, and that of their parents and families. The literature suggests that clinicians need to expand their treatment beyond the child victim, to encompass the family (Dyb et al. 2003; Grosz, Kempe and Kelly 2000; Kiser et al. 1991; Manion et al. 1998; Reyman 1990). There is also evidence that a higher overall level of support from caregivers is linked to better adjustment in children following sexual abuse. In addition, interventions targeted at non-offending caregivers may have a positive effect for both the caregiver and the victim (Kiser et al. 1991; van Toledo and Seymour 2013).

In a study by Grosz et al. of the treatment of 246 child victims of extra-familial sexual abuse, the majority of cases of abuse (60 per cent) occurred in a non-institutional context (perpetrated by a babysitter, friend or neighbour, for example) and at least 14.5 per cent occurred in an institutional context (such as a day-care setting). It is unclear whether the remaining cases occurred in an institutional context (Grosz, Kempe and Kelly 2000). A rigorous evaluation of the treatment was not possible as baseline data from the time of referral was not collected in a format that allowed for comparison after treatment. However, given the scarcity of treatment studies relating to institutional child sexual abuse, findings from this study are worth considering:

- A family-centred approach to intervention is essential for child victims of extra-familial sexual abuse.
- A crucial element in the recovery of the child victim was the family's response to the disclosure of abuse, and its ability to support the victim.
- A further significant factor in recovery for child victims was the parents' capacity to resolve their own distress and to support their child.
- Group treatment of child victims gave them immediate relief as they saw they were not the only victims and that other children had found ways to cope effectively.
- A concurrent parent support group assisted parents at a time when many were feeling isolated from regular support systems.

In this same study, 48 of the 246 families who received treatment also completed a follow-up survey about the treatment program. Parents most commonly identified the mother's support and individual counselling as the most important factors for the child's recovery. Group and individual treatment for parents were identified as the most important factors in their recovery.

In another study, data was collected retrospectively from the clinical records of alleged victims of child sexual abuse in a day-care centre who had received specialised mental health treatment. The study did not consider the effectiveness of the treatment in alleviating the children's psychological problems due to the effects of ongoing litigation (Mowbray and Bybee 1995: 34). However, it did find that:

- children attended an average of 41 therapy sessions and mothers attended more therapy sessions than fathers
- the length of therapy did not relate to pre-existing child or family problems or to the severity of the abuse. Instead, children who experienced a moderate number of life crises and changes during therapy (for example, illness, hospitalisation, the death of a family member or parental separation) tended to stay in therapy longest. Children experiencing few or many life changes both had therapy of significantly shorter duration
- play and individual therapies were the most frequently used modalities for the majority of treatment goals. Group therapy was not used. The largest number of therapy sessions focused on resolving the child's feelings about the abuse and reducing self-blame
- family therapy was planned in a minority of cases for all goals, and even for goals relating to family problems it was only listed as the planned approach in 53 per cent of cases.

While scant, this evidence suggests that treatment and support should be tailored to whether the victim has experienced child sexual abuse within a residential institutional context or in a non-residential institutional setting.

Clergy-perpetrated child sexual abuse

Fogler et al. 2008 reported that no clinical trials had been conducted specifically with survivors of clergy-perpetrated abuse and our evidence review did not locate any new clinical trials or outcome studies. In terms of the support and treatment needs of survivors of clergy-perpetrated child sexual abuse, the literature suggests that:

- Mental health professionals play a pivotal role in recovery from abuse. In Easton's study, where 62 per cent of participants were victims of clergy-perpetrated child sexual abuse, 42 per cent reported their most helpful discussion was with a mental health professional (Easton 2013).

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- The distinctive dynamic between mental health symptoms and spiritual/existential disruptions needs to be a focus of treatment (Fogler et al. 2008).
 - The unique nature of the abuse suggests that attending a support group might be a successful addition to individual treatment, as it may validate experiences and decrease interpersonal isolation of clergy-abuse survivors (Isely et al. 2008). The therapeutic approach should involve psychosocial education, to understand human sexuality and the dynamics involved in sexual abuse; support in building interpersonal skills and developing supportive peer relationships; and consideration of the effect of the sexual abuse on the survivor's spiritual beliefs and practices (Isely et al. 2008).
 - The spiritual dimension that may accompany this type of child sexual abuse should be considered by clinicians in their therapeutic interventions, as a survivor's progress in therapy may be influenced by the clinician's willingness to address the spiritual problems created by sexual abuse and to help the survivor draw on their spiritual resources (Pargament, Murray-Swank and Mahoney 2008).

Fogler et al. published the results of one intervention that has potential for treating the spiritual dimensions of clergy-perpetrated abuse (see Murray-Swank and Pargament 2005). While the participants in Murray-Swank and Pargament's study reported improved religious experiences and spiritual wellbeing following the intervention, there are numerous limitations to their study. The participants were not survivors of clergy-perpetrated abuse, but of intra-familial abuse; the sample size was very small (two); and the treatment was predicated on a belief in God, which not all survivors of clergy-perpetrated abuse will share.

Population Group 2 – Service and support needs of Aboriginal and Torres Strait Islander people who have experienced child sexual abuse

There is consensus in the literature that the sexual abuse of Aboriginal and Torres Strait Islander children must be viewed in the context of the historical legacy of colonisation, racism, deprivation, the forced removal of children from their families and ensuing intergenerational trauma (ACSAT 2006; Atkinson 2013; Cox 2008; Funston 2013; Hunter 2008; Stanley, Cadd and Pocock 2003; Wild and Anderson 2007). Linked to this history are a range of factors that increase the vulnerability of Aboriginal and Torres Strait Islander children. These include higher rates of exposure to domestic and family violence, and alcohol abuse than non-Aboriginal and Torres Strait Islander children (Bath 2013; ACSAT 2006; Wild and Anderson 2007) and ongoing socio-economic disadvantage. Specifically:

- Aboriginal and Torres Strait Islander people are around three times more likely than non-Aboriginal and Torres Strait Islander people to be unemployed (17 per cent compared with 5 per cent) (ABS 2012).
- Twenty-five per cent of Aboriginal and Torres Strait Islander people aged 15 and over reported Year 12 or equivalent as the highest year of school completed, compared

with 52 per cent of non-Aboriginal and Torres Strait Islander people (ABS 2012).

- Aboriginal and Torres Strait Islander people are more likely than non-Aboriginal and Torres Strait Islander people to suffer from a range of health conditions, including asthma, hearing problems, heart disease, diabetes and high blood sugar levels (ABS 2013).
- Aboriginal and Torres Strait Islander people are more likely than non-Aboriginal and Torres Strait Islander people to smoke tobacco, engage in risky drinking³ and be overweight or obese (ABS 2013).
- In 2012, Aboriginal and Torres Strait Islander children accounted for 26 per cent of suicides of people under the age of 15 (ABS 2014), although they comprise only 5.5 per cent of the total Australian child population (AIHW 2014: vi).
- The age-standardised avoidable death rate for Aboriginal and Torres Strait Islander peoples in 2012 was more than three and a half times higher than for non-Aboriginal and Torres Strait Islander people (497 per 100,000 compared with 136 per 100,000) (ABS 2014).
- The Aboriginal and Torres Strait Islander population has a younger age structure than the non-Aboriginal and Torres Strait Islander population, with a median age of 21.8 years, compared with 37.6 years (ABS 2011). The comparatively high number of children and young people in Aboriginal and Torres Strait Islander communities has consequences for the capacity of communities to meet the needs of children and young people, including the availability of grandparents as carers (Bromfield, Higgins, Higgins and Richardson 2007).

Reports of child maltreatment, including child sexual abuse, is higher among socio-economically disadvantaged families (Stanley, Tomison and Pocock 2003). The stresses caused by such disadvantage are associated with maladaptive coping and dysfunctional behaviour, and may increase the potential for abusive or other harmful behaviours in families (Stanley, Cadd and Pocock 2003; Wild and Anderson 2007). However, it is also possible that such families also more readily fall under the 'welfare gaze'. Importantly, not all child sexual abuse experienced by Aboriginal and Torres Strait Islander people is intra-familial or even intra-community abuse. In the past, many Aboriginal and Torres Strait Islander people were forcibly separated from their families to live in residential institutions or other placements. In addition, Aboriginal and Torres Strait Islander children continue to be involved in the child protection system at higher rates than non-Aboriginal and Torres Strait Islander children (AIHW 2014).

The report *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Wilson 1997) presents evidence of widespread sexual abuse of Aboriginal and Torres Strait Islander children who had been forcibly

³ Noting that Aboriginal and Torres Strait Islander people are more likely to abstain from drinking alcohol than non-Aboriginal and Torres Strait Islander people (AIHW, 2011; ABS, 2013).

removed from their families in accordance with government policies. Across Australia, at least one in every six witnesses to that inquiry reported sexual abuse in the institution or placement in which they were forced to live (Wilson 1997: chapter 11). This figure underscores the number of Aboriginal and Torres Strait Islander survivors of child sexual abuse who may not as yet have received any therapeutic support for their adverse childhood experiences.

Prevalence

There is no clear data on the prevalence of the sexual abuse of Aboriginal and Torres Strait Islander children (Hunter 2008; Stanley, Tomison and Pocock 2003). Most estimates are based either on child protection data or on incidents of sexual assault reported to the police. Neither of these measures provides a clear picture of the prevalence, and is likely to lead to underestimates of the problem, as the majority of child sexual abuse is never disclosed by victims. Even where the abuse is disclosed, it is not necessarily reported to the police. The Australian Institute of Health and Welfare (AIHW) estimates that less than 30 per cent of sexual assaults are reported to the police and that Aboriginal and Torres Strait Islander people are less likely to report sexual assault than non-Aboriginal and Torres Strait Islander people (AIHW 2014: 13).

In 2012, there were two to four times more sexual assaults on Aboriginal and Torres Strait Islander children aged 0–9 than on non-Aboriginal and Torres Strait Islander children of the same age (depending on the jurisdiction), and two to three times more assaults on Aboriginal and Torres Strait Islander children aged 10–14 (AIHW 2014: 13). An analysis by the NSW Ombudsman of NSW Police data relating to 12 NSW communities found that 23 per cent of reported victims of sexual abuse aged 0–15 were of Aboriginal or Torres Strait Islander origin, but Aboriginal and Torres Strait Islander children made up just 12 per cent of all children living in these communities (NSW Ombudsman 2012: 84). Statistics collected by state and territory governments on their child protection systems show an over-representation of Aboriginal and Torres Strait Islander children. The AIHW (2014) report shows that in 2012, Aboriginal and Torres Strait Islander children were 10 times as likely to have been placed on care and protection orders and in out-of-home care across Australia.

Disclosure and reporting of child sexual abuse by Aboriginal and Torres Strait Islander people

The majority of children who are sexually abused do not disclose the abuse until many years later, as adults, if at all. For Aboriginal and Torres Strait Islander child sexual abuse victims and their families, a reluctance both to disclose abuse and report it to authorities is complicated by experiences of historical injustice and racism (Funston 2013; Hunter 2008).

In addition to factors such as shame and guilt, as well as threats, manipulation and intimidation by the perpetrator, other factors underlie the low rates of disclosure and

reporting of child sexual abuse by Aboriginal and Torres Strait Islander people. These include:

- fear of violence and intimidation by other community members if a disclosure or report is made (Hunter 2008; McCalman et al. 2014; Stanley, Tomison and Pocock 2003; Wild and Anderson 2007)
- fear that the victim may be ostracised by the community (Stanley, Tomison and Pocock 2003; Wild and Anderson 2007)
- mistrust of authorities and the system, due to past experiences of forced removal of children and other historical injustices (ACSAT 2006; Mace, Powell and Benson 2014; Stanley, Cadd and Pocock 2003; Wild and Anderson 2007)
- a sense of betrayal of the kinship group (Cox 2008)
- fear of the shame that will be brought on the extended family and the community (Mace, Powell and Benson 2014; Wild and Anderson 2007)
- normalisation of violence in some Aboriginal and Torres Strait Islander communities, making it unlikely that child sexual abuse would be reported (Wild and Anderson 2007)
- concern to protect the perpetrator, arising from the high rate of Aboriginal and Torres Strait Islander deaths in custody (Funston 2013; Greer and Breckenridge 1992; Stanley, Cadd and Pocock 2003; Stanley, Tomison and Pocock 2003)
- in some cases, geographic isolation and lack of infrastructure (for example, public transport) or support services, lack of information about child sexual abuse and how to respond to it, and having no one to whom to report the abuse (ACSAT 2006: 54).

Do Aboriginal and Torres Strait Islander victims of child sexual abuse have distinctive service and support needs?

The overview above highlights the unique factors that affect the support needs of Aboriginal and Torres Strait Islander victims of child sexual abuse. These factors include the importance of extended family and community relationships; intergenerational trauma and historical injustices, which continue to exert influence; and ongoing socio-economic disadvantage.

In light of these factors, many Aboriginal and Torres Strait Islander people consider Western methods of support, such as standard counselling, alienating and ineffective (ACSAT 2006; Arnott et al. 2010; Cox 2008; Cripps and McGlade 2008; Funston 2013; Libesman 2004). This is borne out by evidence that Aboriginal and Torres Strait Islander people are less likely to engage with non-Aboriginal and Torres Strait Islander support services (Caruana 2010; Cox 2008; Cripps and McGlade 2008: 243). The limitations of Western support services identified in the literature include:

- the provision of a single counsellor in an unfamiliar room for a fixed period of time (ACSAT 2006; Cox 2008)

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- the question and answer format of most counselling approaches (ACSAT 2006)
 - working with individuals in isolation from their extended family and community (ACSAT 2006; Libesman 2004)
 - the compartmentalised, individualistic and pathologising approach to maladaptive behaviour offered by Western psychology (Caruana 2010: 4 citing McCabe)
 - the fact that the non-Aboriginal and Torres Strait Islander professional may be viewed as a power figure, creating an unequal and uncomfortable relationship (Cox 2008)
 - a lack of funding for services, which means they cannot provide a longer intervention period to allow Aboriginal and Torres Strait Islander clients to engage with and trust the worker and the service (Breckenridge and Huppert 2010).

A number of sources consider how to more effectively support Aboriginal and Torres Strait Islander victims of child sexual abuse. Their conclusions are summarised below.

Cultural competence in service delivery for Aboriginal and Torres Strait Islanders

The capabilities of individuals, organisations and systems vary when it comes to understanding and engaging with the complex histories, cultures and contemporary social dynamics of Aboriginal and Torres Strait Islander populations (Bainbridge, McCalman, Clifford and Tsey 2015). Approaches designed to improve individual awareness of particular aspects of Aboriginal and Torres Strait Islander cultures and to enhance the design and delivery of services also vary.

One of the more encompassing concepts is that of 'cultural safety'. Cultural safety, a concept developed in Maori care, involves working with individuals, organisations and communities to improve indigenous people's experiences of services, making them undiscriminating and culturally responsive, and delivering them in a safe and respectful environment (Coffin 2007; Dunbar 2011). Cultural safety means an environment that is safe for people, 'where there is no assault, challenge or denial of their identity' (Williams 1999). Cultural safety highlights the need for systematic change aimed at empathetic and reflective practice (Bainbridge et al. 2015) based on shared respect, shared meaning, shared knowledge, shared experience and shared learning (Williams 1999).

A less encompassing concept that is commonly referenced in the context of service delivery is 'cultural competence'. The term is regularly used to describe specific strategies aimed at improving the awareness, knowledge and skills of professionals. Use of these strategies helps service providers develop a better understanding of Aboriginal and Torres Strait Islander histories, cultures and world views (Bainbridge et al. 2015; Downing, Kowal and Paradies 2011). In service delivery contexts, Aboriginal and Torres Strait Islander cultures and phenomenology can inform behaviours, symptoms and recovery. Careful attention must be paid to ensure that phenomenology is not pathologised during diagnosis and care (for example, it is common for Aboriginal and Torres Strait Islander people to experience the

voices of their relatives, and clinicians have been known to misinterpret these voices as hallucinations and misdiagnose psychosis) (Parker and Milroy, 2010).

Cultural competence obliges the individual to focus on behaviours, attitudes and policies. Cultural safety is different from cultural competence in that it focuses on the environment rather than the individual. Part of creating a culturally safe environment may include, but would not be limited to, providing a culturally competent service.

In the literature identified in this review, researchers use the term 'cultural competence'. However, it is worth noting that nomenclature in this area is inconsistently applied and terms such as 'cultural security', 'cultural competence', 'cultural awareness' and 'cultural safety' are used interchangeably or are not well defined or distinguished (Coffin 2007).

In an evaluation of a mobile outreach service supporting victims of child sexual abuse in the Northern Territory, the cultural competence of support services and respectful engagement with communities were considered to be of equal or even greater importance than the specialist counselling and support services (Success Works 2011). Participants in a National Yarn Up on service provision for Aboriginal and Torres Strait Islander victims and offenders of child sexual abuse stated that, as a way of ensuring cultural competence, non-Aboriginal and Torres Strait Islander clinicians should receive compulsory training and ongoing cultural safety supervision (Funston 2013). Feedback to the Aboriginal Child Sexual Assault Taskforce in NSW similarly suggested that non-Aboriginal and Torres Strait Islander counsellors and support workers need to have a deep understanding of culture and the effect of child sexual abuse on Aboriginal and Torres Strait Islander people and communities. This was necessary to enable them to respond in a culturally appropriate way (ACSAT 2006: 171). Cox suggests that counsellors and support workers offer informal meetings or home visits to Aboriginal and Torres Strait Islander clients, as transport can be difficult, office environments can be alienating, and the home setting helps to redress the power imbalance of which many Aboriginal and Torres Strait Islander people are acutely conscious (Cox 2008).

The cultural background of workers

Much of the literature suggests that Aboriginal and Torres Strait Islander victims of child sexual abuse would prefer to use support services provided by an Aboriginal and Torres Strait Islander worker, or to at least have the option to see such a worker if they prefer (ACSAT 2006; Funston 2013; McCalman et al. 2014; Success Works 2011). Some Aboriginal and Torres Strait Islander child sexual abuse survivors would prefer not to see an Aboriginal and Torres Strait Islander worker. This is due to concerns about confidentiality, especially if the worker is connected to the survivor through extended family or community ties. Because of this, it is critical that non-Aboriginal and Torres Strait Islander workers are culturally competent (ACSAT 2006; Cox 2008; Funston 2013; Success Works 2011).

Extended family and community

The significance and interconnectedness of individuals, extended family and community in the lives of Aboriginal and Torres Strait Islander people must be taken into account when providing support to child sexual abuse victims (Stanley, Tomison and Pocock 2003: 20). The responsibility for child welfare in many Aboriginal and Torres Strait Islander communities rests with the extended family or kinship network, not just the biological parents, and there may be a practice of moving children between adults – an approach that may conflict with accepted Western notions of child welfare (Stanley, Tomison and Pocock 2003: 20). Feedback from stakeholders in the Northern Territory mobile outreach service for Aboriginal and Torres Strait Islander victims of child sexual abuse found there was broad support for counselling and other services for children, but with the stipulation that children need to be engaged and supported within the context of the family (Success Works 2011).

Partnership and involvement with Aboriginal and Torres Strait Islander communities around support services

The history of dispossession and forced removal of children means that partnership with, and the involvement of, Aboriginal and Torres Strait Islander communities in developing and delivering child sexual abuse services is especially important. This partnership should cover all stages of program development, including planning, delivery and measurement (Davis 2007; F2004; Lohoar 2012; Stanley, Tomison and Pocock 2003). Similarly, service providers and support workers need to take time to get to know and understand the community, and earn the trust of community members. They also need to foster an understanding of Aboriginal and Torres Strait Islander culture and community needs among non-Aboriginal and Torres Strait Islander staff (Lohoar 2012; Funston 2013; Mace, Powell and Benson 2014).

Mental health and counselling services for Aboriginal and Torres Strait Islander people are insufficient

Widespread evidence shows there are insufficient counsellors and support workers to respond to child sexual abuse in Aboriginal and Torres Strait Islander communities. This is especially so for communities in rural, regional and remote areas (ACSAT 2006; Hunter 2008; NSW Ombudsman 2012; Wild and Anderson 2007), and includes a shortage of specialist sexual abuse counselling services (NSW Ombudsman 2012).

Healing programs and Aboriginal and Torres Strait Islander child sexual abuse

The literature increasingly focuses on healing programs for Aboriginal and Torres Strait Islander child sexual abuse victims and their families, as part of the response to intergenerational trauma more broadly among Aboriginal and Torres Strait Islander communities (Arnott et al. 2010; Atkinson 2013; Caruana 2010; Feeney 2009; Payne, Olson and Parrish 2013). In 2009, the Australian Government established the Aboriginal and

Torres Strait Islander Healing Foundation, which has increased research in this area (Gilmour 2013; McKendrick et al. 2012).

The NSW Ombudsman notes that Aboriginal and Torres Strait Islander leaders have advised that targeted healing programs are essential for Aboriginal and Torres Strait Islander victims of child sexual abuse and for the broader community. These programs need to address the effects of violence, trauma and dislocation associated with very disadvantaged communities and the impacts of intergenerational trauma (NSW Ombudsman 2012: 40).

However, while there is evidence of a growing number of healing-oriented programs, their evaluation is still in the early stages (Gilmour 2013; NSW Ombudsman 2012; McKendrick et al. 2012), and it is unclear how effective they are for victims of child sexual abuse. For example, in Canada and the US, where healing programs are being developed to deal specifically with the effects of child sexual abuse (McKendrick et al. 2012: 72), programs often have a restorative justice focus. They can be oriented towards the offender and criminal justice responses to the abuse, not necessarily the mental health or therapeutic needs of victims (for example, the Hollow Waters program – see Cripps and McGlade (2008) for an analysis). Nonetheless, evidence is emerging that healing programs may have beneficial outcomes for victims of trauma generally (Arnott et al. 2010; Payne, Olson and Parrish 2013).

Aboriginal and Torres Strait Islander healing programs have key features that distinguish them from other support services for Aboriginal and Torres Strait Islander people (Arnott et al. 2010; Caruana 2010; McKendrick et al. 2012). These include:

- being driven by local Aboriginal and Torres Strait Islander communities to respond to local issues
- having Aboriginal and Torres Strait Islander ownership and leadership, including in the design and evaluation of services
- addressing spiritual, cultural and emotional needs, as well as mental and physical needs
- focusing on familial and community interconnectedness, not only on the individual
- being aware of the impact of colonisation and intergenerational trauma and grief
- taking a proactive rather than reactive focus
- possibly addressing the healing required by those who have hurt others, as well as those who have been hurt, in recognition of the fact that offenders have often been victims of abuse and intergenerational trauma themselves (NSW Ombudsman 2012: 40).

While a shift to a trauma-informed approach may be clinically helpful, broadening the focus of the intervention brings methodological constraints in terms of evaluating effectiveness for child sexual abuse survivors. These constraints occur because the issue of child sexual abuse is obscured in the broader focus on trauma, and a more complex research

methodology is required to demonstrate the effectiveness of interventions for child sexual abuse alone.

Interventions, programs and research relating to Aboriginal and Torres Strait Islander victims of child sexual abuse

Twelve years ago, Stanley, Tomison and Pocock (2003) noted that very few interventions were then operating to address child abuse in Aboriginal and Torres Strait Islander communities, and none had been evaluated for effectiveness (p 26). Little appears to have changed since then. In a recently published paper, researchers stated they were unable to identify any peer-reviewed intervention studies relating to mental and public health responses to sexual assault for Aboriginal and Torres Strait Islander people (McCalman et al. 2014). Even looking more broadly – at trauma-focused interventions for Aboriginal and Torres Strait Islander children and families (not necessarily only for child abuse) – Atkinson (2013) notes that data from such interventions is very rare in peer-reviewed literature (p 1). As a result, when Aboriginal and Torres Strait Islander clients leave programs, very little is known about the impact these services may have had on them (Lohoar 2012).

Appendix Two outlines specific interventions or programs for, or research relating to, Aboriginal and Torres Strait Islander people who have experienced child sexual abuse. This includes three child sexual abuse-related Aboriginal and Torres Strait Islander healing programs, an international experimental study relating to Aboriginal and Torres Strait Islander child sexual abuse victims from the peer-reviewed literature, and two recent qualitative evaluations of government initiatives to improve responses to child sexual abuse in Aboriginal and Torres Strait Islander communities.

Population Group 3 – Service and support needs of people with disability who have experienced child sexual abuse

‘Disability’ in the literature reviewed generally refers to physical, sensory, cognitive/ intellectual or psychiatric disabilities. Much of the literature on child sexual abuse and disability relates to people with an intellectual disability. In literature from the UK, the term ‘learning disability’ is often used to refer to people with a cognitive or intellectual disability. Some of the literature from the US and elsewhere uses the term ‘mental retardation’ to refer to intellectual or cognitive impairments. The term ‘intellectual disability’ in this chapter is used instead of, and as a synonym for, ‘learning disability’ and ‘mental retardation’.

Prevalence

There is clear and reliable evidence from the US of the higher incidence of sexual abuse among children with disability (Stalker and McArthur 2012), as noted in the studies described below:

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- Sullivan and Knutson's (2000) analysis of the school records of 4,503 children in Omaha, Nebraska found that children with disability were three times more likely to be sexually abused than children without disability. Of children with disability who were sexually abused, those with behavioural disorders had the highest relative risk probability for abuse (5.5 times higher than children without disability), followed by children with intellectual disability (four times higher), and speech or language impairment (almost three times higher).
 - In her 2004 survey of all people listed on the Norwegian deaf register (n = 1,150), Kvam found higher rates of child sexual abuse among deaf people than among hearing people. The rates of abuse were 46 per cent in deaf girls, compared to 31 per cent in hearing girls and 42 per cent in deaf boys, compared with 16 per cent in hearing boys.
 - A recent systematic review and meta-analysis of studies on the prevalence and risk of violence against children with disability found that for all types of violence (including sexual violence), children with disability are at significantly greater risk of violence than children without disability. The study also found that children with mental and intellectual disabilities seem to have a higher prevalence and risk of sexual (and other forms of) violence than children with other types of disability (Jones et al. 2012).

Disclosure and reporting

As with child sexual abuse in general, there is evidence that abuse of children with disability is under-reported (Stalker 2012) and that rates of non-disclosure of child sexual abuse by children with disability are high (Briggs 2006; Kvam 2004). There is also evidence that child sexual abuse is less likely to be disclosed by children with a severe disability than non-disabled children (Kvam 2000). A recent Turkish study of records of forensic examinations of children suspected of being sexually abused found that disclosure and reporting of sexual abuse by children with intellectual disability occurred later than for children without intellectual disability (Soylu et al. 2013).

There is a range of reasons why most children are reluctant to disclose child sexual abuse and delay disclosure for many years (Breckenridge, Cunningham and Jennings 2008). For children with disability, research highlights additional factors that make disclosure of sexual abuse or reporting to authorities, less likely. These include:

- difficulty communicating (Burke, Bedard and Ludwig 1998; Martinello 2014; McEachern 2012; Stalker and McArthur 2012, citing Akbas)
- lack of understanding that they have been sexually abused due to cognitive impairment (Briggs 2006; Martinello 2014; Monahan and Lurie 2003)
- difficulty in distinguishing non-abusive touch from abusive touch due to ongoing reliance on personal care (Briggs 2006; Martinello 2014; Monahan and Lurie 2003)
- fear that disability support services will be interrupted or removed (Brown 2011;

Burke, Bedard and Ludwig 1998; Lund 2011; Monahan and Lurie 2003, citing Sobsey 1991)

- fear that they may be removed from their family and/or institutionalised (Brown 2011; Burke, Bedard and Ludwig 1998; Lund 2011; Monahan and Lurie 2003, citing Sobsey 1991)
- expectation – reinforced by their dependence on family and caregivers – that people with disability unquestioningly comply with caregivers' instructions (Martinello 2014; McEachern 2012)
- a lack of opportunity to report abuse to authorities, due to the ongoing presence of, and dependence on, caregivers (Dowse et al. 2013).

Based on her study of the hospital records of children suspected of being sexually abused in Norway, Kvam (2000) suggests that caregivers appear not to recognise child sexual abuse in a child with disability, or to report it to authorities, unless or until it is obvious (p 1081).

There are a number of possible reasons for this, including:

- difficulty understanding the child's verbal communication (Burke, Bedard and Ludwig 1998; Kvam 2000)
- a lack of understanding of non-verbal signals such as loss of appetite, sleeping problems, nightmares, rage, apathy (Kvam 2000)
- mistaking non-verbal or behavioural indicators of abuse for issues relating to the child's disability, such as incorrect medication, fear of future hospitalisation or bullying (Kvam 2000)
- the greater likelihood that caregivers will know what is going on but fail to acknowledge it if the child has a disability (this occurred for 43 per cent of children with disability in one study, compared to 11 per cent of children without disability) (Kvam 2000, citing Crosse)
- myths about the 'asexuality' and 'insensitivity to pain' of people with intellectual disability, which present barriers to some caregivers acknowledging child sexual abuse (Mansell, Sobsey and Calder 1992).

The impact of child sexual abuse on children with intellectual disability

While there is a lot of evidence about the psychological effects of sexual abuse (including child sexual abuse) in the general population, there is less 'hard' evidence (such as controlled trials) of its impact on people with an intellectual disability (Sequeira and Hollins 2003).

Studies on the clinical effects of sexual abuse of people with intellectual disability suggest a range of psychological symptoms similar to those reported by sexual abuse victims in the general population. These include PTSD, depression, psychosis, dissociative symptoms, self-harm and alcohol abuse (Sequeira and Hollins 2003). However, a review of these studies states that, due to methodological limitations (for example, few of the studies

describe how they assessed the psychological effects of the abuse); the studies' findings are not conclusive (Sequeira and Hollins 2003).

More recently, a Turkish study that was based on assessments by psychiatrists using diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders IV* found similar rates and types of psychological conditions among children with and without intellectual disability who were victims of sexual abuse (including PTSD and major depressive disorders). There were also higher rates of conduct disorders among child sexual abuse victims with disability (Soylu et al. 2013). Sullivan (1993) stated that children with intellectual disability who have been sexually abused exhibit significantly more behaviour management issues than children with intellectual disability who have not been abused (Sullivan 1993: 122). Behavioural problems such as tantrums and aggressive acting out are often indicators of abuse, and non-compliant behaviour may be the only available means for a child with intellectual disability to communicate about or avoid abuse (Sobsey and Mansell 1994).

Additionally, other factors known to be associated with depression and other psychological problems are even more prevalent among people with intellectual disability. These factors include low levels of social support, poorly developed social skills, low socio-economic status and heightened family (especially maternal) stress (Emerson 2013; Tomasulo and Razza 2006).

Does sexual abuse of children with disability have distinctive features?

The literature suggests the sexual abuse of children with disability has distinctive features that directly address research question 1. Recognition of these features is vital to understanding the support and treatment needs of children with disability who have been sexually abused.

Vulnerability to abuse

People with disability may be at greater risk of sexual abuse due to distinctive factors such as placement in congregate care settings and contact with multiple service providers (Brown 2011; Curry et al. 2009). In addition, children with intellectual disability are less likely to recognise abuse as wrong, understand their rights and report abuse, or be regarded as competent witnesses in court proceedings (Briggs 2006). Other factors associated with a child's intellectual disability may increase their vulnerability to sexual abuse, and affect support needs following the abuse, including:

- isolation or a lack of socialisation
- problem-solving difficulties, cognitive limitations, poor short-term memory and vulnerability to stress
- limited communication skills
- limited knowledge about sex and sexuality

- greater and prolonged dependency on others for personal care and other assistance (Mansell et al. 1997).

Severity of abuse

A recent Turkish study reviewing files and case reports of forensic examinations of child sexual abuse victims (102 with intellectual disability and 154 without) found higher rates of penetration among children with disability (vaginal: 36 per cent; anal: 28 per cent) compared with children without disability (vaginal: 23 per cent; anal: 12 per cent). The study also found that children with intellectual disability were exposed to more frequent repeat abuse than children without intellectual disability (Soylu et al. 2013).

Kvam's 2004 study found a greater proportion of deaf victims experienced more serious abuse than did hearing victims: 25 per cent of deaf girls and 14 per cent of deaf boys experienced penetration, compared with 8 per cent of hearing girls and 3 per cent of hearing boys.

Extra-familial (institutional) child sexual abuse

The risk of extra-familial (specifically institutional) child sexual abuse is much higher for people with disability as a result of the contact they have with staff of specialist disability services (Grossman and Lundy 2008, citing Curry and Navarro; Mansell, Sobsey and Calder 1992; Sobsey and Mansell 1994; Soylu et al. 2013).

In Sobsey and Mansell's study, 47 per cent of child sexual abuse perpetrators accessed their victims through specialised services for people with disabilities, as caregivers (rather than peers). Similarly, in Kvam's 2004 study of people on the Norwegian deaf register, only 19 per cent of child sexual abuse was intra-familial and 57 per cent of perpetrators were from a special school for the deaf. However, it is unclear what proportion of school-related perpetrators were students and what proportion were staff.

Male child sexual abuse victims

There is some evidence that boys make up a higher proportion of sexual abuse victims among children with disability, compared with child sexual abuse victims without disability (Kvam 2000). Kvam's survey of all people listed on the Norwegian deaf register (n = 1,150) found that a higher proportion of sexually abused deaf children were male, compared with the proportion of males among sexually abused hearing children (Kvam 2004). This is reinforced by Briggs' 2006 study, which found that, in a sample of 116 special education students in New Zealand, sexual abuse was equally common for boys and girls.

Access to support services and treatment for child sexual abuse victims with disability

Lund's literature review of services and interventions for people with disability who have experienced interpersonal violence suggests that, while service providers might consider that they provide accessible services, the perception of people with disability is that services are not fully accessible, especially in dealing with communication or cognitive limitations (as opposed to physical access) (Lund 2011). Survey responses from 119 people with intellectual disability (not all were children) who were victims of sexual abuse found that 54 per cent had difficulty accessing treatment, and people with severe or profound disabilities were significantly more likely to have difficulty accessing services (Mansell, Sobsey and Calder 1992).

A recent survey of Australian service providers, including mental health and sexual assault services, found evidence suggesting that while the mental health sector is the first point of contact and help-seeking for many women with disability who have experienced violence (including sexual abuse), there is poor identification and disclosure of violence against women and girls with disability among mental health services. In addition, the survey found it is likely that significant numbers of women and girls with disability who have experienced violence do not access any type of service (Dowse et al. 2013).

Inadequate service responses

Studies by Mansell et al. of sexual abuse victims with intellectual disability found:

- Only a minority of victims received treatment that adequately met their needs (29 per cent of people with mild or moderate disability and 7 per cent of people with profound or severe disability) (Mansell, Sobsey and Calder 1992).
- Many victims required accommodation for their needs, which was not available (43 per cent of people with mild or moderate disability and 78 per cent of people with profound or severe disability) (Mansell, Sobsey and Calder 1992).
- Even when attempts were made to accommodate a child with disability, children and their carers regarded these as inadequate (Mansell et al. 1997).

There is also a concern that services may be 'referring on' so that people with disability are caught in a cycle of successive referrals without receiving support, with the eventual result that some no longer seek help (Dowse et al. 2013: note that this study is of women and girls with disability, not males, and it covers violence against women and girls, not only child sexual abuse).

Siloed service systems

People with disability rarely receive therapy specifically adapted to their needs. This is because service providers with a knowledge of disability have little understanding of therapy,

and many clinicians who might provide therapeutic treatment have insufficient knowledge of the special needs of people with disability, especially intellectual disability (Dowse et al. 2013: 52; Lund 2011: 175; Kvam 2000: 1083; Mansell, Sobsey and Calder 1992). In addition, specialist disability services generally do not have the capacity or expertise to recognise or deal with overt violence, including sexual abuse (Dowse et al. 2013: 56).

Treatment and intervention for child sexual abuse victims with disability

There is very little empirical, peer-reviewed literature on, and no controlled trials of, treatments and interventions for people with disability who were sexually abused as children (Lund 2011; Monahan and Lurie 2003; Stalker and McArthur 2012). Consequently, it is difficult to make clear recommendations for clinical practice (Lund 2011: 179). Much of the literature relates to people with intellectual disability, and there has been a common view among mental health clinicians that people with intellectual disability are unsuited to traditional insight-oriented therapies because of their limited language and abstract-conceptual abilities, and this may have hindered the development of more appropriate treatment approaches (Mansell, Sobsey and Calder 1992).

Therapeutic approaches

A review of the literature in this area reveals:

- There is evidence of the efficacy of a therapeutic intervention for deaf children who had been sexually abused, which used therapists fluent in sign language (Sullivan et al. 1992; Sullivan 1993). See below for an overview of this study.
- Therapy goals for children with disability who have been sexually abused may also involve a psycho-educational element, as these children are often not given basic sex education. This may include information on human sexuality, sexual preference, social interaction skills and self-protection techniques (Sullivan 1993).
- It is possible to adapt verbal and non-verbal therapies (for example, play and art therapies) for people with intellectual disability, including psychodynamic, behavioural, cognitive and other techniques (Howlett and Danby 2007; Lund 2011; Mansell et al. 1997; Mansell, Sobsey and Calder 1992; Mevissen and de Jongh 2010; Razza and Tomasulo 2005; Tomasulo and Razza 2006), although there are no treatment studies that clearly establish efficacy.
- There is some evidence that non-verbal strategies may be particularly useful when working with sexual abuse survivors with intellectual disability (Lund 2011: 178, citing Barber et al. 2000 and Cooke 2003).
- Group therapy may be particularly useful for people with intellectual disability who have experienced sexual abuse, as a way of developing socio-sexual skills, promoting social interaction and reducing isolation (Mansell et al. 1997. See also Razza and Tomasulo 2005; Tomasulo and Razza 2006).
- While case reports on the treatment of PTSD for people with intellectual disability

(many of whom experienced sexual abuse) suggest positive effects for a range of different treatment methods, including Eye Movement Desensitization and Reprocessing EMDR, cognitive behavioural therapy and psychodynamic therapy, treatment for this cohort is still in its infancy and there are no empirically based treatment methods (Mevisen and de Jongh 2010).

Rape crisis centre counselling for sexual abuse survivors with intellectual disability

Howlett and Danby (2007) documented a pilot program in the UK that provided access to counselling at a rape crisis centre for six female survivors of sexual abuse (including in childhood) who had an intellectual disability. The program used a 'person-centred framework' and a wide variety of art materials, picture books, clay and toys. Clients received a one-hour counselling session each week, for six weeks, with the option of continuing if required. Clients were surveyed about their views of the service after six weeks. They reported feeling 'generally happier' after the counselling, felt they had alternative methods for coping with anger and managing self-harm, felt a growth in confidence and self-esteem, and were learning to identify people they could trust and rely on. However, these outcomes were not assessed using a validated tool.

The authors concluded that a mainstream rape crisis centre can adapt its services for people with learning disability. Note that the counsellor had previous experience working with people with intellectual disability – this may have been crucial to the success of the program.

Psychotherapy for deaf victims of child sexual abuse

Sullivan et al. (1992) present findings from a study of 72 deaf children who were sexually abused at a residential school for the deaf in the US. An untreated comparison group emerged naturally when the parents of some children refused the offer of treatment, and these children were not treated elsewhere. Children in the treatment group received two hours of individual therapy per week for 36 weeks from therapists who were fluent in sign language and had 'expertise in the psychology of deafness' (p 300). The authors state that communication problems (due to deafness) required a longer than usual therapy session.

The Child Behaviour Checklist (CBC) scale – covering, for example, internalising symptoms such as depression, externalising symptoms such as aggression, somatic, schizoid, uncommunicative and other symptoms – was used to assess a random selection of children before therapy began, and all children following completion of therapy. The researchers found a powerful treatment effect for both boys and girls, and that children receiving treatment had significantly fewer behavioural problems on CBC measures one year after receiving treatment than children who did not receive the therapy.

Group psychotherapy for sexual abuse survivors with intellectual disability

Tomasulo and Razza have published accounts of their adaptation of a group psychotherapy approach for people with intellectual disability who are survivors of sexual abuse, called

interactive behavioural therapy (IBT) (Razza and Tomasulo 2005; Tomasulo and Razza 2006). IBT uses modified standard techniques from psychotherapy and psychodrama in which therapy is not limited to cognitive tasks of thinking and talking, but involves behaviour and emotions (Tomasulo and Razza 2006). The authors state that even individuals with an IQ score in the range of severe intellectual disability would be evaluated for participation in a group; the key criteria are that individuals can comprehend and communicate sufficiently to engage in the group process (Razza and Tomasulo 2005). While some evaluation studies point to the effectiveness of this therapy in supporting people with intellectual disabilities (see Tomasulo and Razza 2006: 90–1), it is unclear whether any of the participants in the evaluation studies had experienced sexual abuse.

Lund also cites a study of a ‘person-focused therapy group’ for women with intellectual disability and a history of sexual abuse. While participants generally showed decreased depression and anxiety at immediate follow-up, the mean depression and anxiety scores were higher at the three-month follow-up than at the pre-therapy group baseline measurement (Lund 2011: 178, citing Barber et al. 2000).

Concluding comments

To explore the service and support needs of the specific population groups identified, evidence has been presented considering whether different groups of survivors have distinctive service and support needs (research question 1); and what the research tells us about interventions targeted at specific groups and about the effectiveness of these interventions (research question 2). The first of these select population groups, children abused in institutional contexts, is the primary group of interest for the Royal Commission. The latter two groups, Aboriginal and Torres Strait Islander communities and people with disability, have been included because of their increased vulnerability to child sexual abuse compared with the general population, their heightened contact (historical and ongoing) with institutional systems, and the distinctive factors that affect their support needs. The literature sourced for this review was able to address both guiding research questions.

Question 1: Do different groups of survivors have distinctive service and support needs?

The evidence demonstrates there are distinctive factors associated with child sexual abuse in an institutional context which may influence victims’ distinctive service and support needs. Victims who were sexually abused in institutions, Aboriginal and Torres Strait Islander children, survivors, and people with disability all report slightly different dynamics and effects. The literature suggests that diverse population groups may benefit from responses tailored to their respective needs.

In particular, certain factors make these victims reluctant to disclose their sexual abuse, such as the significance of the institution in society, the role of the perpetrator within the institution, or an institutional culture that punishes or dismisses disclosures. Other distinctive attributes of child sexual abuse in an institutional context that distinguish these experiences

from child sexual abuse perpetrated outside institutional contexts may include:

- a global loss of trust extending to other institutions sanctioned by society
- a fear of, or disrespect for, authority
- ostracism or victimisation by other members of the community who are involved with the institution
- a crisis of faith, if the abuser was a member of the clergy
- mental health consequences for the family of the victim as a result of the abuse
- public and media attention, which is an additional stressor for victims and their families.

Services and supports for Aboriginal and Torres Strait Islander people should be informed by an enhanced understanding of, and engagement with, the complex histories, cultures and contemporary social dynamics of Aboriginal and Torres Strait Islander populations. Linked to this history are a range of factors that increase the vulnerability of Aboriginal and Torres Strait Islander children. These factors include higher rates of exposure to domestic and family violence and alcohol abuse than non-Aboriginal and Torres Strait Islander children; the tendency of their communities to have a younger age structure than the non-Aboriginal and Torres Strait Islander population generally, creating implications for children and young people through the availability of care; and, ongoing socio-economic disadvantage for a substantial number of Aboriginal and Torres Strait Islander people and communities.

Children with disability experience higher rates of sexual abuse, and are at greater risk of sexual violence, than children without disability. The literature notes their reliance on personal carers and necessary interactions with a range of institutional supports increases their vulnerability to sexual abuse. There is some evidence too that a greater proportion of sexually abused children with disability experience serious sexual abuse (that is, penetration) compared to sexually abused children without a disability. There are additional factors that make disclosure and reporting of child sexual abuse less likely when the victim has a disability. These include (depending on the nature of the disability) difficulty communicating; a lack of understanding of abuse due to cognitive impairment; reliance on personal care; and fear that disability support services will be removed.

Question 2: What does the research tell us about interventions targeted at specific groups and about the effectiveness of these interventions?

The literature review found emerging evidence that the particular context and dynamics of institutional child sexual abuse may affect treatment and supports offered. While there is limited empirical evidence on the effectiveness of particular supports or treatments for people who have experienced child sexual abuse in an institutional context, qualitative studies with survivors of child sexual abuse in residential institutions point to the value of long-term, specialist psychological support. However, many survivors have not been able to receive these services. For victims of abuse in non-residential institutions, such as day-care

centres, there is evidence of a strong link between the functioning of child victims, and that of their parents and families, suggesting that clinicians should ensure their treatment encompasses the family, not just the individual victim. For clergy-perpetrated child sexual abuse, research points to the need for treatments to consider the effect of the sexual abuse on the survivor's spiritual beliefs and practice.

Moreover, research points to a range of factors that may lead to more effective support services for Aboriginal and Torres Strait Islander people who have experienced child sexual abuse, such as:

- enhancing support workers' understanding of, and engagement with, the complex histories, cultures and contemporary social dynamics of Aboriginal and Torres Strait Islander populations
- giving victims the option of seeing an Aboriginal and Torres Strait Islander support worker if preferred
- recognising the interconnectedness of individuals
- acknowledging the importance of extended family and community in the lives of Aboriginal and Torres Strait Islander people
- partnering and involvement with Aboriginal and Torres Strait Islander communities to develop and deliver child sexual abuse support services.

There is also an increasing focus in the literature on healing programs for Aboriginal and Torres Strait Islander child sexual abuse victims and their families and communities. Evaluation of healing programs is still at a formative stage. It is unclear how effective these programs are for victims of child sexual abuse, as many child sexual abuse-related healing programs have a restorative justice focus and do not appear to provide therapeutic support for victims or survivors. In addition, these programs do not always distinguish between Aboriginal and Torres Strait Islander survivors of intra-familial child sexual abuse and institutional abuse.

Less is known about treatments for people with disability who experience child sexual abuse. The literature suggests that support services for people with disability who have experienced child sexual abuse are not fully accessible, especially in dealing with communication or cognitive limitations. Researchers also point out that survivors with disability rarely receive therapy specifically adapted to their needs, as disability service providers generally have little understanding of therapy (especially therapy related to child sexual abuse). In addition, many counsellors or therapists have insufficient knowledge of the special needs of people with disability, especially intellectual disability.

While there is very little empirical, peer-reviewed literature on treatments and interventions for people with disability who were sexually abused as children, research nonetheless supports the view that it may be possible to adapt verbal and non-verbal therapies for people with intellectual disability, including psychodynamic, behavioural, cognitive and other

techniques – although there are no treatment studies that clearly establish efficacy. There is some evidence too that group therapy may be particularly useful for people with intellectual disability who have experienced sexual abuse, as a way of developing socio-sexual understanding, promoting social interaction and reducing isolation.

Overall, this literature review highlights the importance of further research to better understand the treatment needs of particular population groups of institutional child sexual abuse victims/survivors. It is not possible to develop one best-practice response that will appropriately address the needs of different victim cohorts, although the literature does helpfully identify some common factors for the consideration of policymakers and clinicians. This gap in the evidence base remains a challenge despite the promising practices that are starting to emerge.

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APPENDIX ONE

Record of searches

1. Support needs of people who have experienced child sexual abuse in an institutional context			
Database	Search terms	Search terms	Search terms
PsycINFO	child* abuse and sex*	institution*	best practice
Cochrane Library	sexual abuse and child*	institutional care	evaluation
EBSCO databases#	child* sex* abuse	cler*	health service needs
ProQuest databases#	pedophilia	church	intervention
Web of Science	sexually abused children	out of home care	mental health
Informit databases#	sexual offences against children	child care	psychological needs
Google Scholar		foster care	support
		residential care	support needs
		extra-familial	survivor*
		non-familial	therap*
		organisation*	treatment
			victim*
(# See note below for a list of databases searched on the specified platform)			

2. Service and support needs of Aboriginal and Torres Strait Islander people who have experienced child sexual abuse

Databases	Search terms	Search terms	Search terms
PsycINFO (Ovid) ProQuest databases# EBSCO databases# Web of Science Informit databases# Google Scholar (# See note below for a list of databases searched on the specified platform)	child* abuse and sex* sexual abuse and child* child* sex* abuse pedophilia	aborigin* indigen*	evidence good practice health service needs intervention needs servic* support systematic review therap* treatment

3. People with disability			
Database	Search terms	Search terms	Search terms
PsycINFO (Ovid)	child* abuse and sex*	disab*	evaluation
EBSCO databases#	sexual abuse and child*		evidence based practice
Web of Science	child* sex* abuse		intervention
Informit databases#	pedophilia		psychotherapy
Google Scholar			service
			support
			treatment
			treatment effectiveness evaluation
			treatment outcomes
(# See note below for a list of databases searched on the specified platform)			

Notes: The following databases were searched on the EBSCO, Informit and ProQuest platforms:

- EBSCO: Family and Society Studies Worldwide; Family Studies Abstracts; Violence and Abuse Abstracts
- Informit: Australian Public Affairs Full Text; Australian Public Affairs Information Service; Aboriginal and Torres Strait Islander Health Bibliography; Australian Family & Society Abstracts Database (and Aboriginal and Torres Strait Islander collection); Families & Society Collection; Health and Society database; Humanities and Social Sciences Collection

- ProQuest: Applied Social Sciences Index and Abstracts (ASSIA); International Bibliography of the Social Sciences (IBSS); PILOTS: Published International Literature On Traumatic Stress; ProQuest Family Health; ProQuest Health & Medical Complete; ProQuest Nursing & Allied Health Source; ProQuest Social Science Journals; ProQuest Sociology; Social Services Abstracts; Sociological Abstracts.

Grey literature was searched for on the following websites:

- Adults Surviving Child Abuse: wwwasca.org.au
- Australian Institute of Family Studies library: www.aifs.gov.au
- Australian National Research Organisation for Women's Safety: www.anrows.org.au
- Child Family Community Australia: www3.aifs.gov.au/cfca/
- Closing the Gap Clearinghouse: www.aihw.gov.au/closingthegap/
- Faith Trust Institute: www.faithtrustinstitute.org
- Mental Health Coordinating Council: wwwmhcc.org.au
- Minister and Clergy Sexual Abuse Survivors: www.macsas.org.uk
- Respond SA: www.respondsa.org.au
- Secretariat of National Aboriginal and Islander Child Care: www.snaicc.org.au
- Sexual Violence Research (formerly Australian Centre for the Study of Sexual Assault): www.aifs.gov.au/acssa/
- Survivors Network of Those Abused by Priests: www.snapnetwork.org
- UNICEF: www.unicef.org.au
- World Health Organization: www.who.int

Search terms differed between databases and platforms; where possible, the search term was drawn from the relevant database's thesaurus (where available) or taken from the database's list of specified subject terms (where available).

Variant spellings were often searched for when databases did not automatically do this (for example, 'behaviour' or 'behavior').

APPENDIX TWO

Specific interventions or programs for, or research relating to, Aboriginal and Torres Strait Islander people who have experienced child sexual abuse

Sexual assault–related healing program: Yorgum Aboriginal Family Counselling Service (Yorgum)

Sources: *Atkinson (2013); Lawrence (2010)*

Yorgum is an Aboriginal and Torres Strait Islander community-controlled family counselling service supporting Aboriginal and Torres Strait Islander people in metropolitan Perth and parts of south-west Western Australia. Yorgum's services include specialist counselling to Aboriginal and Torres Strait Islander children who have experienced sexual abuse or witnessed family violence, family violence counselling and community education. Yorgum offers sand-play therapy (particularly with children), art therapy, yarning therapy, one-on-one counselling, group work and education workshops, as well as practical support and referral to other services.

All Yorgum staff members – counsellors, art therapist and registered psychologist – are of Aboriginal or Torres Strait Islander origin, and Yorgum is strongly rooted in Aboriginal and Torres Strait Islander culture, philosophy, history and community. The service also applies the 'healing principles' of recognising the individual's interrelated physical, emotional, spiritual and cultural needs, and the interconnectedness of the individual, his or her extended family, and the community. Yorgum's services have not yet been formally evaluated.

Child sexual abuse-related healing program: We Al-li training program

Sources: *Atkinson (2013); Caruana (2010)*

Established in 1993, We Al-li is a training course that comprised a series of workshops that incorporate Aboriginal and Torres Strait Islander cultural practices and therapeutic skills for practitioners working in areas of trauma, including sexual abuse, family violence, substance abuse and positive parenting. We Al-li was designed by and for Aboriginal and Torres Strait Islander practitioners, both to support practitioners to heal their own trauma and to prepare them to support children and others in their recovery. A key component of the program explores areas relating to child sexual abuse, such as:

- cultural safety when working with children who have been hurt
- child development and childhood trauma
- emotional first aid and emotional release work through sensory and tactile work, dance, narrative, movement, play therapy, nature discovery, storytelling and performance

- applying skills for working with children that promote positive spiritual and cultural growth and identity.

We Al-li was incorporated into the Master of Aboriginal and Torres Strait Islander Studies at Gnibi College of Indigenous Australian Peoples at Southern Cross University. It is also delivered at community level. Participants who have completed the course have reported reductions in trauma symptoms. However, Atkinson notes that further research is needed to determine whether the program represents a best-practice model.

Child sexual abuse-related healing program: Pathway to Hope

Source: Payne, Olson and Parrish (2013)

The Pathway to Hope program was developed by and for Aboriginal communities in Alaska, US in response to decades of community and individual historical trauma, much of which related to child sexual abuse, and was compounded by a culture of silence. The program aims to end denial of child sexual abuse in Aboriginal communities by facilitating community dialogue on child sexual abuse and guiding communities in the design of culturally specific healing strategies. In particular, it aims to:

- raise awareness of child sexual abuse and its impact
- motivate people to recognise and report suspected child sexual abuse
- support healing strategies for child sexual abuse victims and non-offending family members
- provide support for community education on child sexual abuse.

A guiding principle of the program is that the reclamation and revival of Aboriginal cultural values, beliefs and practises to heal children and adults who have experienced child sexual abuse 'must begin with understanding historical trauma and in multigenerational dialogue'.

The program has not yet been formally evaluated, so we are limited to anecdotal reports of its effectiveness. These indicate that the program is in demand and successful. It has helped to bring about changes, including the establishment of child advocacy centres, the passing of a 'Children's Bill of Rights' by tribal governments, and an annual 'Protecting and Honouring Our Children' conference.

Experimental study: Outcome of therapeutic intervention for a group of Aboriginal child sexual abuse victims in Canada

Source: Holland, Gorey and Lindsay (2004)

The characteristics of 10 sexually abused Aboriginal (First Nations) children in care in British Columbia who participated in the Sexual Abuse Intervention Program (SAIP) program for an average of one year were compared with those of 56 similarly abused Aboriginal children in

care in Ontario who did not receive SAIP treatment. The SAIP intervention is described as client-centred, involving individual counselling, family support and group work (psychoeducational and social skills training) in a case management model.

Outcomes were based on workers' recorded descriptions of children's mental health and behaviour. The children who received the SAIP intervention did better on a number of measures, including the prevalence of mental health problems (20 per cent for those who received the SAIP intervention, compared with 48 per cent for the children who did not receive treatment) and the prevalence of behavioural problems (20 per cent for SAIP children, compared with 59 per cent for non-SAIP children). Both of these results were statistically significant.

Note that this study has a number of limitations, including the small sample size; uncertainty about how the sample was selected; the inclusion of two or three non-Aboriginal children in the non-SAIP comparison group; lack of clarity about whether the non-SAIP treatment group received no treatment at all, or 'treatment as usual'; lack of detail about the methods workers used to record children's mental health and behavioural problems, and whether or how workers' assessments were standardised; and no consideration of other possible mediating factors that may have affected the findings, such as characteristics of the care placement, or of the family of origin.

Evaluation: Operation RESET

Source: Mace, Powell and Benson (2014)

Mace, Powell and Benson recently conducted a qualitative evaluation of the Operation RESET program in Western Australia. This program is a multi-agency strategy for responding to child sexual abuse in remote Aboriginal and Torres Strait Islander communities. It involves a mobile multi-disciplinary specialist child abuse team made up of detectives and social workers. The program philosophy is to recognise the underlying causes and contextual issues associated with the abuse, to view child sexual abuse as a shared responsibility, and to empower families and communities so that they are able to enhance children's safety.

The evaluation consisted of in-depth interviews with 64 stakeholders who lived or worked in regions where the program had been operating for 18 months. Interviewees revealed strong support for Operation RESET's implementation and outcomes, and emphasised especially valuable aspects of the program: the proactive outreach approach; dedication to capacity building; holistic focus; and the establishment of relationships that facilitated trust.

Evaluation: Northern Territory Mobile Outreach Service Plus (MOS Plus)

Source: Success Works (2011)

In 2011, Success Works evaluated the Australian Government's MOS Plus service, which provides counselling, support and related services to address trauma related to child abuse and neglect in remote areas in the Northern Territory. The objective of the service is to provide 'culturally safe' responses, including therapeutic services, to Aboriginal children, adolescents and their families.

Success Works analysed service administrative data and consulted more than 100 people from government, non-government organisations, outreach service providers and local community organisations, as well as individual community members. The evaluation found:

- This is an evolving service model that requires time to engage respectfully with the community and to adapt and be responsive to community and service needs.
- There was support for the key principles and characteristics of the MOS projects.
- Many Aboriginal and Torres Strait Islander people in remote communities did not know or understand the roles of the MOS service or of MOS staff.
- Families support the participation of children and young people in counselling sessions, with the stipulation that children need to be supported within the context of the family.
- Families, community members and local agencies were developing an understanding of child abuse and related trauma as a result of participating in community meetings, community education and other activities, and were developing skills in dealing with children experiencing trauma.