CASA Forum
Victorian Centres Against Sexual Assault

Royal Commission into Victoria's Mental Health System

Submission

July 2019

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Acknowledgements

CASA Forum wishes to acknowledge and thank member agencies who contributed to this submission either directly or indirectly, through case studies, conversations and feedback.

We also wish to acknowledge our service users, the clients that we work with, whose experiences of sexual assault in their homes, in the community, in institutions, told through case studies, have informed this submission.

Thanks also to Sabin Fernbacher whose assistance in pulling together research about the links between sexual assault, trauma and mental ill-health; and alternative service frameworks was invaluable.

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ABOUT THE CASA FORUM

CASA Forum was established in 1992 and is the peak body for fifteen Centres Against Sexual Assault (CASAs) in Victoria, including the Victorian after-hours Sexual Assault Crisis Line (SACL). We are represented on a wide range of government policy and practice bodies within Victoria, providing advice and advocacy re the development of statewide policies, programs and services.

CASAs are funded by the Victorian Government to provide a range of sexual assault counselling and support services to victims/ survivors of sexual assault, and their non-offending family members/carers and friends. We understand sexual assault to occur along a continuum that includes any uninvited sexual behaviour that makes the recipient feel uncomfortable, harassed or afraid; unwanted touching or remarks; sexual harassment; coerced sexual activity; rape with physical violence and threat to life; and sexual assault of children and the grooming of children that accompanies this crime.

CASAs work with people of all genders who have experienced sexual assault and sexual violence. The majority of our clients are women, who have experienced sexual assault in an intimate partner relationship; were sexually abused as children; have experienced date rape; or sexual assault by a stranger or recent acquaintance; or have experienced sexual assault within an institutional setting.

Children also make up a large proportion of CASA clients. They have most often been sexually abused by a family member. We provide immediate crisis responses to victim/survivors of recent sexual assaults. Crisis Care responses may also involve police and medical personnel. The majority of crisis care responses are provided to women and children. While the number of male victims accessing our services has increased, in most cases they are men seeking support to deal with the impact of historical childhood sexual assault perpetrated by trusted adult males or within institutions.

CASAs also work with increasing numbers of trans and gender diverse people who are victim/survivors of sexual assault. Transgender and gender non-conforming people experience sexual assault at higher rates than the general population and are also at increased risk of being diagnosed with a mental disorder.

Many CASAs also now provide treatment services and programs for young people who demonstrate sexually abusive behaviours, with a view to intervening early to stop the problematic behaviour and support them to develop healthy attitudes and approaches to relationships. We also provide a trauma informed counselling program at the Dame Phyllis Frost Centre, for incarcerated women.

In addition, CASA Forum provides Standards of Practice to guide the work of our services; a statewide workforce development training program for the sexual assault field; education and training for other sectors; respectful relationship programs in secondary schools; and advanced personal safety programs in primary schools.

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INTRODUCTION

> ***What is a normal human response to being violated, abused, humiliated, betrayed, perhaps by someone you love and trust, and being forced to keep a secret?***
>
> *What if it happens when you're a two-year old, or a ten-year-old child, and you're sexually abused by your father, your stepfather, your uncle, or your brother?*
>
> *What if you're a teenager, or a young woman who is raped after attending a club, by someone who you thought was a friend, or by a group of so-called friends?*
>
> *What if you're sexually assaulted in your marriage, or in your trusted relationship, and this becomes something you come to endure over many years.*

It is a normal human response to feel fear, shame, and wonder if you somehow deserved it, or if it was your fault, to feel somehow 'bad' and 'wrong'. It's a normal human response to being violated and abused to lose the sense of it being safe to be who you are, to find it difficult to make sense of what has happened, and why, and lose confidence in yourself and how you are able to move in the world. It's a normal human response to lose the sense of integrity of your being.

How old you are, and how it plays out in your life from that time on will depend on how old you were, whether you were able to tell, whether anyone asked, whether anyone else suspected, what they did about it, how they responded and if there was support.

If you're little and something so unthinkable has happened to you, and you've had your sense of self shattered by this experience, and you haven't been able to tell anyone, you may have to hold it for a very long time.

All these factors have implications for what you end up living with, what you hold in secret for any period of time, how you manage that, what your coping strategies are. The sense of dis-ease that accompanies this violation of your selfhood is a normal human response. Without timely and appropriate support, for some this dis-ease can manifest in ways that become impossible to hold any longer.

Without appropriate support, without a response from friends or family or a service or a system that can help you normalise your response, and help you understand that while something bad happened to you, you didn't do anything wrong, the mental dis-ease intensifies. Some people dissociate; some self-harm; and some end up in a mental health system that labels the symptoms of the dis-ease, without looking into the cause of this mental distress. Some can bear it no longer and suicide.

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A system that labels the symptoms of dis-ease, and medicates, but that doesn't take account of the trauma you've experienced is one that retraumatises and reinforces the sense of 'wrongness' and 'badness'.

CASA Forum welcomes the Royal Commission into Victoria's Mental Health System.

Responding to clients who are victim /survivors of sexual assault is core business for CASAs. Our clients present in crisis, arising from past or recent sexual assault. Many report that they have struggled for years trying to find appropriate support to help them deal with and recover from the trauma and impact of their experiences. Many have had dealings with the mental health system along the way.

Our services try to undo some of that damage. We also try to change systems that by labelling symptoms, and not getting to the root cause of the dis-ease, have added to the layers of shame that service users feel.

We want the mental health system to start from a place of understanding normal human responses to violence and abuse and in particular, to sexual assault; and by trying to understand "what happened to you", rather than "what's wrong with you". The system needs to be re-designed, so victim survivors are assisted to talk and to tell, to normalise and make sense of their responses, and begin a process of recovery from the trauma.

We also want the mental health system to understand the social, cultural and political context in which sexual assault is able to thrive, and the gendered nature of sexual assault.

This submission provides information about the nature, prevalence and health costs of sexual assault in our community; and a summary of evidence and research that details the links between sexual assault, trauma and mental ill-health.

We called for case studies of clients who had presented to CASAs for support related to experiences of sexual assault, and who had had contact with mental health services and systems. In particular we wanted to know what clients would say about how their experience of sexual assault and mental ill-health were linked.

We wanted to know what they would say about the impact of sexual assault on their lives, including mental health impacts; their experiences of the mental health system; and what they would say about the response they received at CASA.

We received twelve de-identified case studies, as well as advice from the statewide Sexual Assault Crisis Line about themes reflected by callers engaged in the mental health system. Ten involved women who were sexually assaulted in childhood and adolescence, and many of those women continued to experience sexual assault into adulthood. Two involved men, one who was sexually assaulted as a child by a family friend; the other by his same sex partner in a long-term relationship.

They told us what they would want the RCVMHS to know about their experience of the mental health system; about the impact of sexual assault and trauma on their mental health; the

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supports that were available to them / what wasn't available; the impact of the intervention they received; and what they would have wanted to happen.

The case studies invariably pointed to serious failings in current responses within Victoria's mental health system. They were also consistent and highly positive about the responses received at CASA.

Our submission speaks to service frameworks and approaches that underpin the work of Victoria's Centres Against Sexual Assault, and the critical role that CASAs and others can play in helping to mitigate the impacts of sexual assault and prevent future mental ill-health in service users.

We have drawn on case studies to draw themes, raise issues and make recommendations about key issues to consider in reforming Victoria's mental health system.

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SEXUAL ASSAULT IN AUSTRALIA

Sexual assault in Australia is prevalent; it occurs across all age groups; it is largely gendered in that most perpetrators are male; and it has lasting impacts for victim survivors. A selection of recent research is outlined below and highlights the prevalence and nature of sexual assault within Australian society.

Personal Safety Survey (PSS)

The *Personal Safety Survey* (PSS), a national survey conducted by the Australian Bureau of Statistics every four years (2008, 2012, 2016 and 2020), collects detailed information from men and women (over 18) about the nature of violence experienced since the age of 15. It is the most comprehensive data source on the prevalence of violence (including family, domestic and sexual violence) in Australia. The most recent data available from the 2016 PSS was released in November 2017.

The 2016 PSS found that, in Australia, since the age of 15:

- One in five women has experienced sexual violence, compared to one in 21 men.
- One in three women has experienced violence by a person known to them, compared to one in four men.

The 2016 PSS also showed that, over time:

- Sexual violence against women increased between 2012 and 2016, from 1.2% to 1.8%.

University of Queensland study (Mamun, Lawlor, O'Calloghan, Bor, Williams. & Najman, 2007)

A 2007 University of Queensland study found:

- 10.5% of males and 20.6% of females reported non-penetrative child sexual assault before the age of 16
- 7.5% of males and 7.9% of females reported penetrative child sexual assault before the age of 16.

Victorian Crime Statistics Agency

- In the year ending 31 December 2016, Victoria Police recorded 12,956 sexual offences across the state, up by 45.0%, up from 8,936 offences in the year ending 31 December 2012.
- Of the 12,956 recorded sexual offences, 16.2% (2,095) remained unsolved as at 18 January 2017.
- 21.3% (2,754) of offences resulted in an arrest and 24.3% (3,146) resulted in a summons being issued.
- Of 7,788 victim reports, 79.7% (6,204) involved a female victim while 18.8% (1,467) involved a male victim. The remaining victim reports involved a victim with an unknown sex.

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The Cost of Child Abuse in Australia Report 2008 (Access Economics Pty Limited, Australian Childhood Foundation and Child Abuse Prevention Research Australia at Monash University)

This report estimates the costs to the economy and society of the abuse of children and young people aged 0 to 17 years, and looked at physical, emotional/ psychological and sexual abuse, as well as neglect and witness of (or knowledge of) family violence.

It identified key research about the prevalence, duration and burden of disease attributable to childhood sexual abuse (CSA).

Prevalence:
Andrews et al (2004) undertook a rigorous meta-analysis of the lifetime prevalence of sexual abuse including twelve studies in Australia and New Zealand. It found:

- Reporting rates of child sexual abuse between 3.4% and 22% in males and between 17.3% and 45% in females.
- On the whole, child sexual abuse was higher in females than in males.
- Lifetime prevalence was 5.9% among males and 29.1% among females.

Duration:
It also examined selected studies related to duration of childhood sexual abuse experienced across a range of cohorts.

Fleming (1997) studied child sexual abuse among a community sample of women.

- This study found that the duration of abuse was more than one year for 43% of episodes.

Gold et al (1996) studied a sample of women entering an outpatient treatment program for survivors of childhood sexual abuse, around half of whom reported abuse by more than one perpetrator.

- They found that for 120 women, the duration of sexual abuse by the first perpetrator lasted on average 5.05 years.

Runtz (2002) studied 775 women enrolled in psychology at a Canadian university who volunteered for a study of women's health concerns. 143 reported a history of childhood sexual abuse and 153 reported a history of child physical abuse prior to age 18.

- This study found that although the average duration of the child sexual abuse was 1.3 years for 15% of the sexually abused women, the duration of the abuse ranged from two to 14 years.
- Only 19% of the abuse occurred over a period of less than one year, and the average duration of the child physical abuse was 6.8 years.

Tyler et al (2002) studied homeless and runaway adolescents.

- They found that the duration of sexual abuse ranged from less than one year to 12 years.

- Although the majority of young people sexually abused reported that the duration was less than two years (71%), for 19% it lasted three to five years, and for 10% it lasted six or more years.
- The average duration of sexual abuse was two years.

Burden of disease of child sexual abuse:
Both the Australian Institute of Health and Welfare (AIHW) and the World Health Organisation (WHO) reported 'child sexual abuse' as a risk factor for disease and injury in their burden of disease studies

The AIHW reported that child sexual abuse was responsible for 0.9% of the total burden of disease and injury in 2003 for Australia; the majority (68.4%) of which was reported to be through anxiety and depression, suicide and self-inflicted injuries as well as alcohol abuse.

Offender/ victim relationship, reporting, conviction rates

A range of Australian studies also provide data about offender/ victim relationship; reporting; and conviction rates:

- The ABS found that 15% of women had been sexually assaulted by a known person compared to 4% who were assaulted by a stranger (Australian Bureau of Statistics - Personal Safety Survey, 2012)
- The ABS reported that 93% of offenders are male (Australian Bureau of Statistics - Recorded Crime - Offenders, 2013-14)

Women with a disability

- In a study of 850 reported rapes in Victoria, 26.5% victims were identified as having a disability. 58.8% of these had a psychiatric disability or a mental health issue and 22.1% were identified as having an intellectual disability. (Heenan & Murray, 2007).

Women in custodial settings

- A survey of 100 women in SE Queensland prisons found that 95% had experienced abuse prior to imprisonment. 98% physical abuse, 89% sexual abuse, 70% emotional abuse and 16% ritual abuse. The majority of women experienced this abuse in childhood and 37% before the age of 5. (Kilroy, 2000)

Indigenous women

- Indigenous women are over represented as victims of interpersonal violence

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LINKS BETWEEN SEXUAL ASSAULT AND MENTAL (ILL) HEALTH

> *Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptation to life (Judith Herman, 1992).*
>
> *Sexual abuse damages that which is at the core of self, (…). To some degree or other, relational traumata are attacks upon humanity (Meares, 2019).*

Sexual abuse, in particular childhood sexual abuse, can have enduring and sometimes devastating effects on a person, in particular if the trauma is not addressed, kept a secret, or if the person is not believed or not supported following disclosure (Anda, Felitti et al. 2005).

Organisations often lack policy guidance and staff training, which are instrumental for staff to feel confident in having conversations about abuse, including sexual abuse (Read, McGregor et al. 2006). Health and mental health professionals often refrain from asking questions or having conversations about current or previous family violence or sexual abuse (Read, Hammersley et al. 2007), despite what is known about prevalence rates.

It is more likely that the victim/survivor discloses sexual assault many years after the sexual abuse occurred. Health professionals, including mental health professionals often respond in less than supportive ways or inappropriately. Such responses are likely to exacerbate a person's distress and mental illness (Lanthier, Du Mont et al. 2018).

The frequency, severity, chronicity and recency of any type of abuse, including sexual abuse, have an impact on an individual's current levels of distress (Briere and Jordan 2004). Whether a child told someone, about the abuse, and if they did, whether they were believed, whether an effective intervention occurred to ensure the safety of the child, as well as coping responses used by the child, all impact on (longer term) outcomes (Read, Fosse et al. 2014).

Writers distinguish between a single event of trauma (or sexual assault) and multiple, prolonged abuse. While both types of abuse can have significant effects on a person, prolonged sexual abuse, that started early in a child's life, is likely to have a greater impact. Judith Herman first coined the term 'complex trauma' to describe the effects of abuse during childhood or adulthood and the sequelae as Complex Post-Traumatic Stress Disorder (Herman 1992, Herman 2017, Kezelman 2019).

The past decades have seen a vast number of research studies demonstrating a link between childhood sexual abuse and mental ill-health.

Childhood sexual abuse has been linked with nearly all types of mental illness: depression and anxiety (Herman 1992); suicidality (Plunkett, O'Toole et al. 2001, Gal, Levav et al. 2012, Angelakis, Gillespie et al. 2019, Kezelman 2019) and suicide, both intended and accidental (Cutajar M, Mullen P et al. 2010, Kezelman 2019). It has also been linked with eating disorders (Briere 1992, Mullen, Martin et al. 1993); Borderline Personality Disorder (Herman, Perry et al. 1989, Krawitz and Watson 2000, Cutajar M, Mullen P et al. 2010, Rao and Beatson 2019); substance use disorder (Poole and Greaves 2012); Post Traumatic Stress Disorder (Briere

1992, Mueser, Goodman et al. 1998); complex trauma/complex post-traumatic stress disorder (Kezelman and Stavropoulos 2012, Kate and Dorahy 2019); psychosis (Read, Perry et al. 2001, Read, Goodman et al. 2004, Cutajar M, Mullen P et al. 2010, Read, Fosse et al. 2014); schizophrenia (Read, Os et al. 2005, Read, Fosse et al. 2014); Dissociative Identity Disorder (Middleton, Dorahy et al. 2008); and Multiple Personality Disorder (Krawitz and Watson 2000).

The Adverse Childhood Experience (ACE) Study demonstrated the link between a range of adverse childhood experiences, and the impact on the health and wellbeing of adults, in particular if the trauma has been unresolved (Anda, Felitti et al. 2006, Felitti, Anda et al. 2019). The ACE study and many other research studies have since provided evidence of the magnitude of childhood/sexual abuse, coping strategies survivors employ and possibilities for recovery.

The link between sexual abuse, in particular childhood sexual abuse and mental-ill health was reaffirmed by the most recent Australian data (Australian Instutute of Health and Welfare 2019), which outlines that

- Women with childhood abuse suffer worse health effects in adulthood;
- For women aged 15 and over, mental health conditions were the largest contributor to the disease burden due to domestic violence[1]; conditions included depressive disorders (43%), followed by anxiety disorders (30%) and suicide and self-harm (19%).

The Australian Longitudinal Study on Women's Health has followed women since the early seventies. It provides evidence of the prevalence and impact of sexual abuse on women over the past decades. It was found that women who have experienced childhood sexual abuse had worse mental health outcomes than those without such abuse, and in particular depression and anxiety (Coles, Lee et al. 2015).

Abuse, including sexual abuse during childhood or adulthood, may not be the one single cause of mental-ill health or mental illness. Neither is it necessarily the only cause for each person who develops a mental illness. However, both a strong link between abuse and its mental health impact, and a high number of people with a mental illness diagnosis have been established.

Of course, not all children who experience sexual abuse develop mental illness and not all people with mental illness have experienced child sexual abuse. However the links between these two phenomena have been repeatedly demonstrated and for those who have experienced childhood sexual abuse, the impact on their sense of self, their place and agency in the world around them and their role in relationships with others are inextricably linked to their experience of sexual abuse.

[1] Sexual abuse is frequently part of the abusive pattern of behaviour by perpetrators of domestic and family violence.

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People diagnosed with Mental Illness

We acknowledge that that not all mental illness is a result of violence, oppression, abuse, trauma or adverse experiences. However, we also note that there is much evidence to indicate that:

> *Childhood trauma is in fact the single most significant predictor that a person will present to a mental health system; the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences (Kezelman and Stavropoulos 2012).*

Those who have experienced trauma, including childhood and adult hood sexual abuse come in contact with mental health services earlier; more frequently (and frequently access emergency mental health services); have more frequent and longer hospitalisations; and spend more time in seclusion (Read, Harper et al. 2018).

People who access mental health services and those diagnosed with mental illness report high rates of (childhood) sexual abuse and other forms of trauma (Read, Fink et al. 2008). The ACE study found that adults with high levels of abuse were 10 times more likely to be prescribed antipsychotic medication and 17 times more likely to be prescribed antidepressants (Anda, Brown et al. 2007).

Some studies show very high rates of abuse and sexual violence for people with mental illness, stating that between 51%-98% of public mental health clients with 'severe' mental illness (schizophrenia, bipolar) have experienced childhood physical and/or sexual abuse (Mueser, Goodman et al. 1998, Cusack, Frueh et al. 2003).

Other studies show lower, however still alarmingly high rates of sexual assault (Read, Harper et al. 2018). An Australian study found that up to 92% of women psychiatric inpatients have histories of childhood abuse, family violence or both (Mouzos and Makkai 2004).

People, in particular women who experience psychosis, schizophrenia, bi-polar disorder and Borderline Personality Disorder have experienced high levels of abuse, with many having experienced multiple forms of abuse, including child sexual abuse and family violence (Khalihef, P. et al. 2014).

Up to 85% of people (mostly women) diagnosed with Borderline Personality Disorder have experienced trauma including physical, sexual, emotional abuse and neglect (Rao and Beatson 2019).

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THEMES ARISING FROM CASA CASE STUDIES

Sexual assault, complex trauma and mental ill-health

Unsurprisingly, case studies received from CASA Counsellor Advocates aligned with research and evidence about the strong links between sexual assault and mental ill-health. This was particularly true for those who were sexually abused as children.

All experienced sexual assault as traumatic and reported that it had seriously impacted their health and well-being. All service users in case studies reported long-term consequences and attributed their mental ill-health to their experience of sexual assault.

CASE STUDY: 'M' – [redacted]-year-old woman

'M' was sexually assaulted by her brother in the family home. She was also assaulted by a family friend 'in a father role' in the family home and later in the perpetrator's home...

'M' reported symptoms of PTSD; anorexia; depression; and suicidality [as impacts of the abuse]. She also reported loss of her childhood; low self-esteem; loss of education; loss of ability to feel connections in life; loss of trust; loss of identity; somatic memories; and flashbacks…

On experiencing flashbacks [redacted] years later, 'M' came to CASA. She found CASA to be welcoming, supportive, and she reported feeling 'heard, actually heard'. However she also said she 'felt too broken to be fixed and went through 3 counsellors in the initial year'.

SECASA

CASE STUDY: 'B' – [redacted]-year-old woman.

'B' was sexually assaulted by her brother in childhood; and experienced family violence by her father throughout childhood and adolescence.

[Mental health impacts included] severe anxiety, depression, and symptoms consistent with complex PTSD; Substance Use Disorder (cannabis and alcohol); suicidal ideation and self-harm; feelings of sadness, emptiness, grief, and shame; disrupted education and employment; difficulties with relationships with other family members; engagement with the criminal justice system through reporting the sexual assaults.

SECASA

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Delayed disclosure: childhood sexual abuse and mental ill-health in adulthood

Many child victim survivors of sexual assault don't disclose the abuse until they reach adolescence or adulthood. Disclosure is often triggered by an event or an experience of acute mental health distress. In some of our case studies, symptoms of distress brought the victim survivor into contact with the mental health system, at which point they may or may not have disclosed the abuse during treatment.

CASE STUDY: 'T' – [redacted]-year-old woman

'T' was raped by her uncle at [redacted]. Like most men in her family, he was physically intimidating and often violent towards others. [She] felt she couldn't tell anyone as she was fearful of the repercussions. If she told, she thought he would kill her or her father might kill him. She also thought her mother and her mother's relationships with her family would be devastated.

When [she] heard her uncle, who had raped her, was coming to stay in her family home, she felt terrified. She was now [redacted] but with very few options… She lived with her mother and three brothers who were often violent and frightening. It wasn't an option for [her] to stay with her father while the uncle visited as he had been physically violent towards her as a child and she was frightened of him.

[She] felt the only way to avoid her frightening uncle's visit was to kill herself. She attempted suicide and was placed in the Royal Melbourne psychiatric ward for a number of days. Whilst there she disclosed the sexual assault as the reason she couldn't go home. She was discharged with a referral to our service and no ongoing mental health services.

WestCASA

CASE STUDY: 'T' – [redacted]-year-old man.

'T' reported that he recently recalled having been sexually assaulted as an [redacted]-year-old boy when visiting a family friend. The perpetrator was unknown to [him] and was described as an older male- possibly in his twenties or thirties. It was a once off event but reportedly had a significant impact on [his] life and sense of self.

He] stated that he believes his childhood sexual assault resulted in his long-term substance use as a form of self-medication and eventual development of schizophrenia. [He] has found it difficult to form and maintain healthy relationships, has difficulty communicating with family and friends-, his confidence and education was impacted, and job opportunities were limited…

[He] initially told his partner what had occurred after having ongoing nightmares and what he referred to as 'flashbacks'. This only took place a year ago when he initially disclosed, and he then told his mental health worker and psychiatrist who suggested he self-refer to CASA.

GVCASA

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Timeliness of responses: early intervention and prevention is critical

The Royal Commission into Institutional Responses to Child Sexual Abuse reported that on average, it took "23.9 years [for survivors] to tell someone about the abuse and men often took longer to disclose than women (the average for females was 20.6 years and for males was 25.6 years). Some victims never disclose." (2017, p9).

Other evidence points to the vulnerability to further sexual abuse (and other relational violence) for children as they grow to adulthood (Lalor & McElvaney, 2010). On a more positive note, however, studies in regard to early/timely intervention have demonstrated the potential for effective outcomes from such intervention (Berkowitz, Stover, Marans, 2011).

Together with what is known about the links between experiences of childhood sexual abuse and mental health, the high possibility and impact of delayed disclosure and the vulnerability for further experiences of abuse, not only do prevention and early intervention become critical, but so also the timeliness and appropriateness of responses. Without timely and appropriate (supportive & validating) responses and early intervention, the potential for the development of mental health difficulties in children and young people increases.

CASE STUDY: 'S' – girl, presented at age [redacted], and again at age [redacted]

S presented to Gatehouse at the age of [redacted] after her disclosure of sibling sexual abuse and subsequent sexual abuse by an older male. Her disclosure was made early and responded to in part by referring her for therapy. However, it was met with mixed responses from her family ranging from distress (for which she felt responsible), anger at her brother (from whom she felt cut off as a result of her disclosure), and blame of her for supposedly "causing" the sexual abuse to occur.

She represented at age [redacted] as a result of peer sexual assault. While S engaged in some effective therapy on her first presentation, she continued to feel the reverberations of her disclosure through her family and in her relationships with different family members. Her sense of responsibility for the abuse remained difficult to ameliorate, while her sense of herself as being of value only as an object to meet others' needs and her understanding of her role in relationships as being primarily sexual were entrenched. At age [redacted] S was displaying significant anxiety symptoms, including panic attacks and was engaging in self-harm (cutting).

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CASE STUDY: 'L' – girl, aged [redacted]

L was [redacted] years old when she disclosed sexual abuse by a maternal uncle. She was referred to CASA after completing her VARE statement with police. L was seen in the early intervention, Child and Family Traumatic Stress Intervention (CFTSI) program which is designed to be delivered in the peri traumatic period (up to three months) following a traumatic experience or disclosure of a potentially traumatic experience. L was experiencing symptoms of PTSD L was seen over 6 sessions, with her parents. CFTSI provides psychoeducation, parent coaching and skill building to target specific symptoms. At the completion of her treatment, L had developed her skills in emotional regulation and her parents reported that she no longer displayed concerning trauma symptoms.

Gatehouse Centre

CASE STUDY: 'D' – teenage girl aged [redacted]

D had been seen at a child and adolescent mental health service (CAMHS) as a result of suicidal ideation and behaviour. She was diagnosed with OCD and emerging borderline personality disorder. In the course of her treatment she experienced a sexual assault by a known male (friend). Following her assault her symptoms increased; however she was discharged from the mental health service and referred to a CASA with the explanation that because she had been sexually assaulted she now needed to go to CASA. While D engaged well at CASA and reported improvements in her mental health as therapy progressed, she experienced the initial discharge from CAMHS as rejecting/abandoning and as evidence that the sexual assault was her fault.

Gatehouse

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Sexual assault, trauma and misdiagnosis within the mental health system

Service users in our case studies indicated that what could be considered 'normal' responses to unbearable trauma often led to contact with the mental health system, resulting in misdiagnosis and inappropriate medicating to manage their symptoms of distress.

CASE STUDY: 'J'-[redacted]-year-old woman

'J' stated her mother couldn't cope with how [she] was impacted by the sexual assault (extreme emotions and "out of control" feelings)… [and] for a period of a year, her mother took her to various psychiatrists until one agreed with her mother's diagnosis that she had bi-polar disorder and placed [her] on medication… J states that for two years she felt like a zombie.

As her mental health deteriorated and after another suicide attempt, at [redacted] years she was admitted to the Royal Children's Hospital, then an inpatient at Orygen Youth services. She was taken off all her medication and was advised that she had been misdiagnosed with bi-polar. J stated that these programs were "fantastic". She felt she was finally listened to and had a voice.

NCASA

CASE STUDY: 'S'-[redacted]-year-old woman

As a child [she] reports that she was sexually assaulted by a neighbour... [and] In the early [redacted]'S [she] was sexually assaulted whist she was an inpatient at a Catholic psychiatric hospital.

In her childhood and adolescence [she] was diagnosed as schizophrenic, a psychopath, having a personality disorder and manic depression. The only diagnosis 'S' agrees with are depression and PTSD.

SECASA

CASE STUDY: 'M'-[redacted]-year-old woman (contd)

The hospital did not treat the sexual abuse when I was admitted for anorexia even though it was mentioned in a family meeting. It was only the eating disorder – I had the eating disorder because that was the only sense of control I had in my life

I was admitted to hospital for PTSD and the hospital could not manage the flashbacks and thought I was having psychotic episodes and wanted to medicate. I was actually sent to my SECASA counsellor from hospital weekly because the hospital did not know how to manage the issue of symptoms

SECASA

CASA Forum
Victorian Centres Against Sexual Assault

Sexual assault survivors need trauma informed, gender sensitive responses

The nature of the trauma experienced by survivors of sexual assault point to the need for gendered, trauma informed responses that include acknowledgement of the prevalence and gendered nature of sexual assault, and the mental health impacts of sexual assault.

Service users in our case studies indicated that when they were in in acute crisis, the responses they received in mental health settings were less than satisfactory – they were instead experienced as insensitive and retraumatising. For some, acute mental health settings were places where they were again sexually assaulted.

CASE STUDY: 'M'-[redacted]-year-old woman (contd)

… I needed the nursing team to sit with me and support me having flashbacks not run away and try to medicate me; I needed to feel safe in the hospital setting and I did not; I felt like rather than dealing with my problem the answer was medicate or label rather than treat me as a person. I was searched and made to feel like a criminal on admission it was dehumanising I was not going in for addiction.

I feel like the underlying issues are not addressed- it is only a surface response and no long-term care and follow up which is why people stay in the system for so long

SECASA

CASE STUDY: 'S'-[redacted]-year-old woman, lesbian, physical disabilities

As a child 'S' reports that she was sexually assaulted by a neighbour.

In the early[redacted]'S [she] was sexually assaulted whist she was an inpatient at a Catholic psychiatric hospital.

Whilst in hospital she was given ECT treatment and prescribed a range of psychiatric medicines including psychedelics. [She] was discharged whilst taking psychedelics and became overwhelmed with suicidal thoughts. She attempted suicide which resulted in the loss of one leg.

Following months of hospital treatment, she was admitted to another psychiatric hospital where she reports she was sexually assaulted by other patients and raped by a staff member

SECASA

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Trauma informed practice skills and professional capability in mental health services

Service users commonly found the lack of trauma informed responses in mental health services and settings added to their distress. Several reported being treated for the mental health symptoms that they were experiencing without any link to the underlying trauma history. This treatment can be experienced by the victim survivor as individually blaming and pathologising.

CASE STUDY: 'H'-[redacted]-year-old woman

'H' has experienced multiple incidents of child and adulthood sexual assault from the age of[redacted], perpetrated by family members, close family friends, ex-partners and male friends. [She] has been diagnosed with Post-Traumatic Stress Disorder, Borderline Personality Disorder, Major Depressive Disorder and General Anxiety. H also disclosed physical health impacts including ovarian damage from the rapes… a miscarriage and extreme weight gain.

… During her first disclosure of abuse, the psychiatrist did not address sexual assault trauma in a therapeutic way or trauma informed way. The psychiatrist was assessing her mental health and the client was asked to provide extensive detail of each sexual abuse. The client stated that she felt it was very intrusive and invalidating. This caused confusion for her as the psychiatrist's primary focus was on the events, not the impacts of the trauma...

[H reported further] multiple incidents whereby she felt mental health professionals did not address her disclosures in a therapeutic and sensitive manner. [She] detailed one example where a psychiatrist had his back to her, typing on a computer, while she detailed her trauma… [She] also disclosed another two incidents whereby she disclosed her abuse to a psychiatrist and a psychologist. She stated that in both these incidents the primary focus was on her symptomology and pathology. She detailed that this left a lasting impact whereby she was extremely afraid to disclose to mental health professionals.

… when she did have the means to access treatment, either through the Medicare rebate or out of pocket payments, she stated that psychologists were often ill equipped to treat her sexual assault trauma. She stated that she would often be informed to see WestCASA for her trauma and continue with a psychologist for her depression and anxiety, despite the acknowledgement that her mental health diagnoses were a result of her trauma history. It seems that the mental health professionals she engaged with had needed training in how to identify and work with complex trauma in a trauma informed way.

WestCASA

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Victorian Centres Against Sexual Assault

Service responses compound or mitigate mental health impacts of sexual assault

Many service users reported that when they contacted their local CASA for support, they felt heard and understood for the first time; and that mental health symptoms were 'normalised'.

Some spoke to the need for mental health services to work in an integrated way with counselling and support services such as CASA and called for a holistic approach based on an understanding of trauma.

CASE STUDY: 'M' – [redacted]-year-old woman (cont'd)

On experiencing flashbacks [redacted] years later, 'M' came to CASA. She found CASA to be welcoming, supportive, and she reported feeling 'heard, actually heard'. However, she also said she 'felt too broken to be fixed and went through 3 counsellors in the initial year'.

SECASA

CASE STUDY: 'H' – [redacted]-year-old woman (contd)

After her initial phone call and intake session [when contacting CASA], the client reports that she felt acknowledged, validated and understood… [and] that her mental health symptoms were normalised and understood as her mind and body's response to sexual abuse instead of being pathologised.

The client noted this was the first instance that this had ever occurred with a counsellor or psychologist.

WestCASA

CASE STUDY: 'B'- [redacted]-year-old woman (cont'd)

'B' and her experience of the mental health system:
Primary mental health services worked well because the service was willing to work alongside SECASA and with a GP. The clinical approach was team oriented and that helped to address the complex mental health/health/social/substance use issues I faced.

A blanket approach to mental health and substance use did not work, clinical interventions need to be tailored to each individual; crisis mental health services were unpredictable, service helped sometime and did not other times, really depended on individual staff members and their attitudes toward substance use and ability to refer on to other relevant services.

Crisis services worked well for me when they were able and willing to provide intensive outreach support for the crisis, showed compassion and understanding, heard what wasn't being said, and didn't just follow a checklist.

SECASA

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WHAT SERVICE USERS WANT THE ROYAL COMMISSION TO KNOW

The impact of sexual assault and trauma on mental health

Service users were united in identifying that their experience of sexual assault had a devastating impact on their lives, and on their mental health. They wanted the Royal Commission to know:

'B': … to be aware of the significance of the impact of traumatic experiences on mental health, particularly sexual assault and family violence, and how this can impact on what a person might need to assist and support them, both long term and in times of crisis.
'M': It is a life changing event and requires a supportive first response. It causes a variety of mental health issues and is often wrongly labelled and treated because of the lack of understanding. We are not crazy.
'V': The sexual assaults directly affected her mental health, but the mental health system did not acknowledge this or support her with establishing safety. The lack of safety she experienced made it impossible to address her mental health issues particularly depression, anxiety etc.
'S': … it is important that all mental health assessments include questions regarding experiences of sexual assault. All discharge plans need to be carefully considered with appropriate ongoing care within the community
'T': [Sexual assault and mental ill-health] are inter- related and need to be addressed in a way that acknowledges this.
'J': [It had a] huge impact. It happened 11 years ago, and my mental health is still really affected. Not been stable since - super anxious- particularly around males.
'H': Sexual assault and trauma are deeply connected to individual's mental health. Prolonged and repeated trauma has profoundly detrimental effect on an individual's mental and physical wellbeing. The current mental health system does not adequately manage disclosures or provide adequate interventions. A mental health care plan does not have adequate number of sessions to address sexual assault and trauma.

Their experience of the mental health system

Clients told us that they were not listened to in the mental health system, and that treatment within that system further negatively impacted upon them. They shared ideas for what needs to change.

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'H': … the mental health care system was clunky and ill-equipped to address complex trauma… the responses to her disclosures and the treatment given was re-traumatising and caused her to disengage from treatment. When she was able to engage, the client found it difficult to continue engagement due to financial cost, limited number of sessions available, lack of diversity in treatment modality and professional reluctance to address sexual assault.
'M': It is not person-centred care. It is not a safe setting. There is an emphasis on medication rather than long term CBT or therapeutic work. There is a massive gap from being in hospital to being back in the community in terms of isolation and support. There need to be more programs in the community that are activity based to rebuild that sense of belonging in the community. People go in and out because there is no transition from hospital to community. I feel like the underlying issues are not addressed- it is only a surface response and no long-term care and follow up which is why people stay in the system for so long. Long term follow-up and support not provided. Lack of understanding about the impacts of sexual assault- a focus instead on presenting symptoms
'V': She would want them to know they did not prioritise her safety. They need not support her around her material needs eg. lack of housing and education. Had this occurred she would not have been in the position she was in to be assaulted again. She was upset that they saw her as BPD and did not seem interested in what had happened to her or what was going on in her life. Had they considered these things she believes they could have supported her much more effectively.
'S': She experienced the most depraved acts of sexual assault whilst she was a child and an inpatient of two separate Mental Health institutions. This should never have happened nor should it happen to vulnerable children in the future.
'T': She would have liked to continue with [the] youth MH service. Continuity of care and a flexible and responsive service that is youth informed is needed. A capacity for outreach service would also be ideal as young people with MH issues struggle with office-based commitments and the travel involved to get there. An understanding of the impact of her complex trauma history on her MH and struggles with life would have also been a helpful response from MH services. A discharge from a mental health facility with no ongoing MH service involvement was also scary for her.
'J': As a teenager J felt she didn't have a voice and that some mental health workers were quick to diagnose and medicate. Parents shouldn't have had the power to influence that her mother did. Now as an adult J states she finds it difficult to access, express and understand her emotions. She feels that if she had had the appropriate treatment as a teenager "at such a significant time of my development", she would have been able to address these issues. As a teenager "I shouldn't have been put on 11 tablets a day"

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The impact of the intervention they received

Service users in our case studies affirmed that the lack of trauma informed care led to feeling retraumatized, and reinforced feelings of shame and that there was something wrong with them.

'H': In the mental health care system, the client stated that her trauma symptoms were often pathologized which led to feeling of invalidation, fear and shame. The client stated that her sexual assault was identified as needing a separate form of therapy as the psychologists did not feel they had the means or time to adequately address it in their counselling sessions. This further highlighted and reinstated feelings of invalidation and shame.
'M': Loss of trust in the health care system. Lack of crisis support
'J': Being misdiagnosed meant that J felt like a zombie between the ages of [redacted] years. Once she received proper treatment and was on appropriate medication, she feels more positive about the support she received.
'V': Whilst youth mental health services were available, they did not address her needs. They actually reinforced to her that there was something wrong with her because she was "attention seeking". When the mental health system fails to believe people about the sexual assault perpetrated against them, they are putting clients at greater risk of harm. This in turn increases mental health symptoms. She found some of the staff kind and compared to her family who did not look after her and were neglectful, she felt relatively safe. As a result of this, when the workers in the mental health system told her that having sex as a [redacted]-year-old with [redacted]-year-old men was just attention seeking she believed them. She states she does want attention because she's never had it or felt loved.
'S': She was perceived purely though a medical lens with no insight into the significant impact early trauma can have on a child.

What service users said they would have wanted to happen

Service users consistently stated that they wanted to be heard, believed, treated with empathy and kindness, and supported to deal with the effects of the trauma they'd experienced.

'M': There needs to be a separate mental health area for sexual assault victims in mental health (like the mother baby units) to address the specific needs and also to have that sense

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of connectedness to others who understand. With professional, trained workers who understand and can respond to flashbacks and PTSD symptoms. Peer support workers that actually have thrived after and can share that hope and sense of there is life after sexual assault but also truly understand the road travelled beyond the theory of a book. Need to have long term programs or day programs to cope with the trauma and understanding and building yourself back up.
'H' The client says that she wishes to be treated with dignity and empathy during disclosures of sexual assault and trauma. She explained that during this process she would have wanted to be validated and acknowledged. [She] wished she had originally been referred to West CASA instead of a psychologist ([redacted]) as West CASA had a better understanding of her trauma in relation to her mental health.
'V': She would like to have been believed when she told the mental health workers what was going on. She would have liked to have been supported and protected. She would like to have not felt like she was the problem or the person doing the wrong thing. She would have liked to have the blame placed on the perpetrators. They should also have been concerned about the adult male offenders targeting her for sex. The mental health system must believe people when they state they have been sexually assaulted, raped and trafficked. The system must follow the law and report to police and child protection.
'J': Needed access to trauma sensitive mental health services.

What worked, what helped

Service users said they felt heard and believed, often 'for the first time' when they attended CASA. They stressed the importance of counselling and support that helped them to understand the impact of the sexual assault they'd experienced, and that normalised their responses.

'H': Through West CASA the client was able to engage in long term individual counselling and two different modalities of therapy (body-based therapy and group therapy). [She] was able to gain a deeper understand of the impacts of trauma on her body and mental health. The client was able to understand that her poor mental health had arisen from the various traumatic events that occurred in her life. They explained that she gained an understanding that her symptoms of depression and anxiety were accumulated survival responses in response to her sexual assault.

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'V': She can now recognise through the work done at CASA House that she can't get her needs met by others as an adult and that she can acknowledge when people have hurt her. This is something the mental health system should have supported her with.
'J': The CASA support she received as a teenager was accessible as the worker attended her school. At the time she lived in a rural area and the closest CASA was 1 and ½ hours away and she would never have attended. Due to the positive experience she had with CASA as a teenager, she knew that when she was ready to deal with her trauma, to return to CASA. Has attended NCASA for 3 sessions and feels she has been able to talk more freely and openly about her trauma than with any mental health worker since her last CASA worker. Feels the trust she developed with her CASA worker as a teenager was crucial

Need for holistic responses

Service users called for more holistic and integrated responses, where multiple issues could be addressed from a trauma informed practice approach.

'B': The mental health system works well when a holistic approach is taken, incorporating services for mental health and substance use disorders into one, when willing to work alongside SECASA services, including SECASA workers in the process, and having an understanding of trauma. Service providers willing and able to work together to provide response to trauma and its impacts. Understanding substance use disorders and its relationship to mental health and trauma. Crisis response willing and able to provide intensive outreach support services, driven by compassion and an understanding.
'J': Have a psychiatrist linked with CASA
'V': The intervention let her know she could talk to some "kind" adults. This was useful. The intervention, or lack of response to the sexual assault disclosure made her more unsafe.
'T': Orygen and CATT responses good. Gave her some confidence in MH service responses in regard to assisting her when she felt unsafe. Individual adult case manager experienced as supportive, but he was constrained in delivering a youth sensitive flexible and ongoing service. MH services to work in collaboration with sexual assault services rather than using them as a MH service alternative

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Gaps in the system

Service users identified gaps in the mental health system, including a lack of trauma informed long-term counselling.

'H': There wasn't a trauma specific, long term, counselling service available in the mainstream mental health system. CASAs… are the only service that provides free, long term, trauma specific counselling. However, West CASA cannot provide acute mental health care and the client was often in need of this service but reluctant to access due to experiences of not being treated with care and respect. [Need] Long term, accessible, affordable and diverse and responsive mental health care that is trauma informed and focused.
'M': It needs to be client centred care with no limits to services provided. It requires trust and more than one approach. No one really listened in the mental health system. The police failed in their response. Other than SECASA there is no long-term support to deal with the impacts of sexual assaults.
'T': No youth MH service once time ran out ([redacted] not appropriate). No outreach-based MH support service. No housing options for youth struggling with trauma related MH issues.
'B': Greater recognition of the impacts of complex trauma (also highlighted in the Royal Commission into Institutional Responses into Child Sexual Abuse) and the need for ongoing support that is flexible and responsive to the person's needs and incorporates an understanding of the impacts of sexual assault and family violence.
'J': More mental health specific services in rural areas that work from a trauma sensitive, rather than a medical model.
'T': Increased capacity of Orygen so that more youth can access for a longer time (if required); RCH MH services to be more responsive to young people who are unable to leave their home due to fear and anxiety; increased capacity for adult MH services to see complex trauma clients for a service that provides responsive continuity of care; for safe housing options to be provided for young women struggling with MH issues and safety issues; for no-one with MH issues to be released from hospital or a correctional facility without clear, immediate, flexible, accessible and ongoing MH service involved (with outreach capacity if needed). For stronger relationships and referral pathways to be developed; for MH facilities to be made safer for women. We have many women reporting sexual harassment and assault in current MH hospitals.

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SUPPORTING RECOVERY AND PREVENTING MENTAL ILL-HEALTH

Given what we know about the strong causal links between sexual assault and mental ill-health, this Royal Commission provides a vital opportunity to investigate service responses that will support recovery from sexual assault and prevent mental ill-health.

Mental health policy and system re-design is essential if we are to find ways forward for a system that is clearly failing victim survivors of sexual assault.

Service models must be founded on sound understandings about the neurobiological, physical, emotional, psychological and social impacts and the trauma associated with sexual assault. Services need clarity and guidance around building effective response and recovery models.

The system must also consider the social, cultural and political context in which sexual assault and violence occurs. Gender blindness in mental health services is not an option for our service users.

CASA Forum submits that consideration of alternative frameworks for understanding and dealing with human trauma and distress will be necessary. This should include a shift towards a social model of mental health that recognises and incorporates knowledge about the impact of sexual assault, violence and trauma on victim survivors. What we know is that responses that pathologise normal human responses to trauma must be transformed.

Neurobiological understanding of trauma

> *The brain is neither predetermined nor unchanging, but rather is an organ of adaptation (Cozolino 2002, pg. 179).*

The impact of trauma, especially early childhood trauma on the developing brain has been well documented over the last decades. It has now been well established that the brain is neuroplastic and changes over time (Doidge 2017). Brain development is impacted by a child's experiences in their social context and interactions. Both positive and negative experiences impact on brain development (Cozolino 2002, Kezelman and Stavropoulos 2018).

The brain develops in a hierarchical way, with lower brain regions (brainstem) developing early. They "control basic life-support functions such as respiration, heart rate, blood pressure, and other critical activities" (Gaskill and Perry 2012). Higher brain regions (limbic and cortex) develop later and more slowly and are less critical to basic survival following birth. They "mediate intricate functions of thinking and emotional regulation" (p. 31).

The theory that brain development is a purely biological process has been disproved by researchers who found that we are not 'hardwired', rather that the brain adapts and changes and is influenced by context and external experiences (Anda, Felitti et al. 2005, Gaskill and Perry 2012, Kezelman and Stavropoulos 2012, Bloom 2019).

While positive stress contributes to learning, stress that is overwhelming and prolonged is likely to impact negatively on brain development. In particular, it impacts the relational templates and stress response mechanisms that become patterned in behavior.

Normal stress, such as missing a parent when starting kindergarten (or going for a job interview), produces short physiological changes, including circulation of stress hormones, increased heart rate and blood pressure. Once stress abates the body adapts and 'settles down'. Prolonged and toxic stress impacts on brain development: "the strong and prolonged activation of the body's stress management system (…) becomes particularly problematic when it occurs during critical developmental periods" (Bloom 2019, pg. 4).

Under stress, brain stem responses become dominant, the brain kicks into 'survival mode', the person is less able to be calm, to reflect and respond flexibly (Kezelman and Stavropoulos 2017). Over time, the repeated patterning of such reactions leads to the person reacting "as if" the trauma was still occurring, when in reality it is not; it is simply the ongoing impact of the trauma that they continue to experience.

To manage constant stress and threat, the nervous system activates responses for protection. These include the 'fight-flight' response (by activating muscles, and organs into a heightened state of arousal, ready to respond); or the 'freeze and dissociation' response (shutting down, ready to protect) (Haskel 2012).

The fight-flight response is a basic human survival response; the nervous system kicks into action if threat is imminent and the person either fights (takes on the attacker) or flees (runs away). This response can be life-saving in a situation where escape is possible, or if the person can overpower the assailant.

The freeze response is markedly different. If there is no way to escape, the body 'shuts down', the "heart rate slows down, preserving blood flow and even simulating death so that a predator loses interest" (Bloom 2019, pg. 5).

Brewin (Brewin 2011)suggest the dissociative response is a 'cutting off' from what is occurring and has been described as the "temporary breakdown in continuous, interrelated processes of perception, memory, or identity" (pg. 211).

In chronic stress the body keeps trying to respond to the stress, without 'having a break' and returning to the baseline (slowing heart rate, less blood pumping). The amygdala's ability to discriminate threat cues becomes impaired, leaving the person in constant hyperarousal and vigilance, alert for any danger.

This also means that a person does not react to threat (real or perceived) from their original baseline, because they do not return to their original baseline. Their "baseline level of arousal" has been changed (Bloom 2019, p. 5), they are constantly in hyperarousal. Survivors of abuse can have quick, strong and intensely emotional reactions to seemingly harmless situations and stimuli.

Being constantly alert, looking out for potential danger, experiencing strong emotions, is not only exhausting, it can also get in the way of forming and maintaining positive relationships with others. People who are on constant hyperarousal are easily triggered into 'flight or fight'.

Attachment and developmental approaches

> *Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of self that is formed and sustained in relation to others (Herman, 1997, p. 218).*
>
> *The personality development of those who have been traumatised does not really stop, but it can certainly become distorted, veered away from a healthy trajectory and onto a new and often more destructive course (Bloom, 2019, p. 20).*

Trauma can have a profound impact on a child's development (Bloom 2019, Newmann 2019) and attachment (Perry 2013, Kobak and Bosmans 2019).

If sexual abuse occurs during early childhood, a child's development and sense of self, their personality, is greatly impacted. Abuse can lead to difficulty in regulating emotions, forming relationships and self-soothing. While other children learn how to self-sooth, how to engage with others, how to form relationships, a child who experiences abuse can appear aggressive, withdrawn, disconnected, spaced-out, fall behind academically, withdraw from school or other social activities.

A child may be occupied with what will happen when they get home, what happened last night, how to protect themselves and find it hard to concentrate at school. Traumatised children find it more difficult to concentrate. This can lead to a range of challenges, including keeping up at school and academically later in life, or concentrating at work (Bloom 2019).

If abuse occurred when the child was pre-verbal, they may have nonverbal memories, which they find difficult to understand or make sense of (Bloom 2019, pg. 11).

While any type of child abuse is traumatic, the age of the child, the age difference between child and perpetrator, and the closer relatedness between victim/survivor and perpetrator, the greater the impact (Courtois and Ford 2019).

"Complex trauma involves forms of assault and ongoing threats of danger that are chronic, ever-present, and usually inescapable" (Courtois and Ford, 2012, pg. 211). This in turn means greater long-term impact on a child's development, mental health and longer-term outcomes as an adult.

Unconscious trauma (trauma that is not consciously remembered because it either happened pre-verbally or it has been pushed away as a way of coping) impacts on development of self and lack of healthy selfhood (Meares, 2019). The disturbance of development of self during childhood and adolescence can lead to a lack of clarity of self. This can be the case for many sexual abuse survivors, not only those diagnosed with Borderline Personality Disorder.

Sexual abuse is a greater predictor of dissociation than physical abuse for children and young people. “A natural, protective response to overwhelming traumatic experiences, dissociation can become an automatic response to stress” (Kisiel and Lyons 2001).

Attachment theory, initially developed by Bowlby (Bowlby 1969), suggests that children learn models of relationships through their caregiver. “The quality of these early interactions and relationships shapes the infant’s emerging understanding of human interaction” (Newman, 2019, pg. 102).

A caregiver’s soothing and comforting response to an infant provides security and safety for the child. In turn, when distressed, the child can return to this safety, or has learned coping strategies to self-sooth (Bowlby 1969). The caregiver’s sensitive response to a distressed infant also provides the child with external stress regulation (Newmann 2019).

The impact of high stress, such as through adverse childhood experiences, including sexual abuse and family violence can have a major impact on both attachment and (personality) development (Newmann 2019). As early as in infancy, children respond to high levels of stress with withdrawal and dissociation (Perry, Pollard et al. 1995).

Borderline Personality Disorder, a highly stigmatized mental health diagnosis, even within mental health service contexts, frequently provokes strong responses to behavior associated with people who have this diagnosis. Trauma informed practice, child development and attachment theory provide helpful ways of understanding some of those behaviors and therefore allow for a different response.

Alternative frameworks for working with victim survivors of sexual assault

CASA Forum submits that the work of the Royal Commission into Victoria’s Mental Health System should be informed by what victim survivors tell us constitutes an effective response.

Mental ill-health arising from sexual assault is common and prevalent among our service users. Counselling and advocacy frameworks that privilege the victims voice and experience, that instruct services and professionals to ‘walk with’ survivors, and that locate the problem of sexual assault in the wider social, cultural and political context are what service users tell us makes a difference.

Centres Against Sexual Assault in Victoria operate from a structural feminist analysis of sexual assault, and are committed to addressing the gendered, cultural, economic and social inequalities that result in the perpetration of sexual assault and violence against women and children. Provision of accessible, effective and consistent quality services to victim/survivors of sexual assault require an understanding of the causes and consequences of sexual assault.

People who have experienced trauma, especially as children, who live in a constant state of hyperarousal develop many coping strategies to manage their reactions, triggers, flashbacks and memories (or lack thereof).

Within a human rights framework, we subscribe to a Victims' Rights Model of service delivery. We make explicit the link between rights, empowerment and long-term healing for victim survivors of sexual assault.

Our service responses are trauma informed; feminist; justice oriented; and intersectional. A number of frameworks that align with CASAs service approach, and that we propose should help inform the way that mental health services respond to victim survivors of sexual assault are outlined below.

Trauma Informed Care and Practice; feminist counselling/therapeutic approaches; anti-oppressive frameworks; and emerging models such as the Power, Threat, Meaning Framework offer ways to make sense of the impact of violence on victim survivors; their responses to trauma; associated presentations, 'symptoms' and behaviours; and offer guidance around working with survivors towards recovery.

Trauma Informed Care and Practice (TICP)

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA 2014).*
>
> *(…) a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services (Jennings, 2004).*

Trauma Informed Care and Practice (TICP) is a framework that provides guidance for organisational cultural change, implementation and practice.

It was developed in response to a lack of understanding by service providers of the impact of trauma on a person's life and an acknowledgment that many organisations and service sectors unknowingly worked with a large number of trauma survivors. These included mental health and Alcohol and Other Drug (AOD) services, which lacked understanding about the large number of people affected by trauma; the many consequences of trauma (including mental health and addiction); and that organisational practices could re-traumatise people (Harris and Fallot 2001, Kezelman and Stavropoulos 2012, Mental Health Coordinating Council 2018).

Changing the focus and asking the question from "*what is wrong with you*" to "*what happened to you*?" symbolises a fundamental shift from a blaming culture to an inquiring culture, and towards understanding of trauma and its impact (Klinic Community Health Centre 2013). What might have been deemed as 'attention seeking' can instead be understood as someone asking for help in the best way they can. Someone applying a TICP lens would consider that the person has experienced trauma and work to assist them, rather than label and punish them.

TICP provides key principles that guide both organisational and individual work. It is a systems-wide approach to reorient all aspects of an organisation to become 'trauma sensitive' (Jennings 2004, Elliot, Bjelajac et al. 2005, SAMHSA 2014, Quadara and Hunter 2016, Mental Health Coordinating Council 2018).

The implementation of TICP as a systems-wide approach entails a range of activities aimed at a thorough review of organisational policies, decision making processes, level of consumer/client involvement on all levels of the organisation, and professional development and supervision for staff.

TICP provides a way of understanding the impact of trauma for survivors, their current wellbeing, distress and behavior. Many survivors of sexual assault report that their behaviors have been labelled negatively, such as 'attention seeking' (self-harm), creating one's own challenges ('risky behavior), or labelled as a mental illness (suicidality/suicide). Many people receive psychiatric diagnoses that can stigmatise, without the recognition of the impact of trauma.

Taking a trauma-informed approach opens up different understandings of a person's distress. People who have experienced trauma cope as well as they can, and for some these coping strategies may work for years.

Coping strategies, while seemingly 'unhealthy', provide temporary relief from a state of hyperarousal, from great distress, flashbacks, triggers, traumatic memory. Over time coping strategies can become unhelpful and can contribute to increased lack of safety for the person. While heavy drinking or taking drugs can help with blocking out memories temporarily, it can also render a person less safe in some circumstances, or their judgment can be impaired.

A much debated and challenged mental health diagnosis is Borderline Personality Disorder. A high percentage of those who receive this diagnosis are women and a high percentage have experienced prolonged and severe child abuse (though not everyone). A more accurate diagnosis, using a trauma informed lens, would likely be the presence of complex trauma (or complex PTSD). This would indicate the need for a different approach to supporting the person in developing new coping skills.

Trauma specific services will be those that can work with someone to increase other types of internal (self-) and external support.

The following table is a brief summary of the differences between traditional mental health language and TICP language. It shows a fundamental shift in attitude, intention and understanding of trauma.

Differences in language and understanding	
Illness focussed	Trauma focussed

Symptom of illness	Symptom of abuse
Symptom	Adaptation to trauma
Paranoia	Legitimate fear
'What is wrong with you?'	'What has happened to you?'
Self-harm	Coping with overwhelming feelings Wanting to feel something
Attention seeking	Trying to build a relationship
Confusing behaviour	Adaptation to trauma

Children and TICP

> *Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early years shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems (Newman, L. in Kezelman and Stavroplous 2012).*

Many of the key concepts of TICP apply to supporting children as they do for adults. Victoria's Child Safety Commissioner (2009) suggested a range of ways to support children and young people within a TICP framework. The 'spiral of healing' promotes several steps to assist children towards recovery from trauma. These include building (safe) relationships; safety (from trauma; telling the story; connection and empowerment (reconnect with family, wider community in safe and healthy ways); providing tools and activities (teaching grounding and soothing).

Others outline similar steps to working with children who have been traumatized: create safety, regulate the nervous system, build a connected relationship, support development of a coherent narrative, practice 'power-with' strategies, build social emotional resilience skills and foster post-traumatic growth (echo 2018).

Feminist counselling approaches

A feminist analysis of sexual assault and abuse is founded on understanding the context of gender inequality and dynamics of power and control in society (McPhail 2016). Brown and

Bryan suggest that "feminist therapy uses analysis of gender, power and social location as a means of understanding the [clients] emotional distress" (Brown & Bryan 2007, pg. 1122)..

Feminist counselling has at its core the notion of supporting women to distinguish between 'internal and external sources of distress', so they do not blame themselves for the reason they are seeking counselling (Richmond, Geiger et al. 2013)[2].

Combining feminist counselling with trauma-informed therapeutic approaches is another way that feminist therapy has been described as helpful (Richmond, Geiger et al. 2013). The authors suggest that the lack of judgment about, for example, self-harm is part of feminist counselling, as are employing non-coercive tactics in reducing-self harm. Providing a safe and supportive environment in which the person does not get judged regarding their use of self-harm is one of the cornerstones of TICP (Kezelman and Stavropoulos 2012).

Similarly, assisting a person to make a link between sexual abuse and current distress, and coping strategies such as self-harm are also part of trauma informed and trauma specific therapy. Both trauma sensitive and feminist counselling work from the stance of not blaming the person and provide non-judgmental engagement.

Because there is no one definition of feminist counselling and because it is not a specific modality, those who practice feminist counselling are "connected through shared values" (Richmond, Geiger and Reed 2013, p. 443).

Anti-oppressive practice (AOP)

> *In its most accessible form, AOP is a lens through which experience is understood. The AOP lens is that of power based on group identities or affiliations (such as race, class, gender, and sexual identity), and when practitioners notice group identities, they can anticipate—for that client, their family, or their community—an array of experiences that are associated with positive or negative life outcomes (such as health, income, education, marginalization, violence, status, and social inclusion/exclusion).*
>
> *The simplest directive for AOP practice is to minimize power hierarchies, by assisting to build the power of those who hold a marginalized identity and/or reducing the unfair power of those of privileged status (Curry-Stevens, 2016).*

Anti-oppressive practice promotes a person-centred, strengths based and critically reflective approach to examining power in providing social services (Dominelli, 2009).

Using an AOP lens, Reynolds challenges current conceptualisation of trauma in the field of psychology, arguing that trauma has been medicalised, obscuring human suffering and violence (Reynolds 2013). Regarding work with sexual abuse survivors, she says that "we need to see women who have experienced sexual assault individually in therapy to assist with their

professional recovery and simultaneously engage the wider community in the social project of resisting and transforming rape culture" (Reynolds, 2018, pg. 27).

Discussing oppression as the real reason for mental illness, Reynold challenges the biologically focused explanatory models of psychiatry. She suggests that mental illness is more directed by pharmaceutical corporations, colonization, sexism, racism and homo/trans/queer phobia than a concern for human suffering (Reynolds 2013). She proposes that is it more accurate to think about people's struggle against oppression, rather than thinking of them as oppressed. People need justice, rather than medication and societal changes against abuse of power. She argues that the problem is the abuse of power by privileged people, not people's brains.

Power-Threat-Meaning Framework

> *The Power-Threat-Meaning Framework ('the framework') is an "overarching structure for identifying patterns in emotional distress, unusual experiences and troubling behavior, as an alternative to psychiatric diagnosis and classification (Johnstone, Boyle et al. 2018, pg. 5)*

The Power Threat Meaning Framework was developed over five years by the Division of Clinical Psychology of the British Psychological Society. Based on a large body of evidence, it examines the problems of medicalisation and psychiatric diagnosis. The authors address some of the underlying philosophical issues and problems with psychiatry, which is based on a western view and assumptions about society and what is 'right', 'wrong', 'mad' and 'sane'. Such philosophy separates mind from body, emotions and thought and the individual from their social group.

It posits that psychiatric diagnosis is inherently limited in making sense of emotional and psychological distress and argues that medicalisation has been a way to try to make sense of human problems. The framework suggests that this has occurred because psychiatry draws on theoretical models that are designed for bodies, not feelings, behavior and thoughts (Johnstone, Boyle et al. 2018).

It promotes a move away from a bio/psycho/social model of mental illness, without assuming pathology and without favoring the 'biological' aspects (as per the traditional psychiatric paradigm).

The framework aims to assist in identifying patterns of distress, how they manifest, the meaning a person makes and what access to power they have. While psychiatry believes that 'symptoms' of mental illness are an expression of a biological illness, the PTM framework suggests that they are "patterns of embodied, meaning-based threat responses to the negative operation of power" (pg. 10).

It integrates evidence about the role of a range of kinds of power in people's lives; demonstrates how power is misused and how people respond to threats (threat responses); and explains how we make meaning and develop narratives of these experiences.

The PTM approach comprises four interrelated aspects. It looks at:

- **Power:** how it operates, including biological/embodied, coercive; legal; economic/material; ideological; social/cultural; and interpersonal. It asks:
    - What has happened to you?
    - How has power operated in your life?
- **Threat:** what the negative operation of power may pose to a person, a group, the community, with a particular focus on emotional distress, and the way this is mediated by biology. It asks:
    - How did it affect you?
    - What kind of threats does this pose?
- **Meaning:** the central role meaning has in the experience and expression of power, threat and our responses to threat; asking:
    - What sense did you make of it?
    - What is the meaning of these situations and experiences to you?
- **Threat Responses:** as a result of the above, the ways an individual, group or community has learned to respond, in order to survive (emotionally, physically, relationally or socially). It asks:
    - What did you have to do to survive?
    - What kinds of threat response are you using?

It then goes on to ask the question of what a person's strengths are (what access to power do you have?) and finally to integrate the experiences and ask about the person's story.

The work is profoundly connected with and was developed collaboratively with people with lived experience. It acknowledges the power of lived experience, as well as trauma and adversity, and advocates fostering respect for the way distress is experienced, expressed and healed. It supports and extends TICP and is a paradigm shift away from psychiatric diagnosis and understanding of 'mental illness'.

CASA Forum
Victorian Centres Against Sexual Assault

CASA FORUM RECOMMENDATIONS

Reorient Victoria's mental health system towards a social model of mental health

In line with frameworks that speak to the social determinants of mental ill-health, in particular the impact of sexual assault and gendered violence, re-design Victoria's mental health system to:

a. Ensure it is informed by evidence and understandings of the impact of sexual assault, violence and trauma on mental health, and in particular the links between childhood sexual assault and mental ill-health in adulthood.
b. Embed trauma-informed policy and practice frameworks in Victoria's mental health system.

Ensure Victoria's mental health system is gender sensitive

a. Develop guidelines for the provision of gender sensitive mental health services for women and girls, in line with international, national and local evidence about best practice to promote safety and recovery.
b. Ensure mental health professionals are trained in gender sensitive responses to victim survivors of sexual assault, and trained in responding to complex trauma presentations
c. Provide women only wards in acute mental health settings

Promote alternative frameworks for working with sexual assault within mental health services and settings.

a. Challenge medical response models that pathologise victim survivors of sexual assault, and promote best practice, rights-based, trauma informed responses.
b. Promote person centred frameworks and therapeutic modalities that align with the needs of service users and with evidence-based best practice recovery responses.

Promote holistic and integrated responses to victim survivors of sexual assault within mental health services.

a. Explore options for developing holistic responses and models for provision of mental health services to victim survivors of sexual assault
b. Provide shared training to promote cross-sector collaboration between mental health services and CASAs
c. Consider pros and cons and options for outreach or co-location of mental health services with other services including CASAs
d. Develop specific guidelines for information sharing of risk and care plans to enhance outcomes for clients.

Early intervention and prevention

a. Develop response and prevention strategies to strengthen and enhance identification of indicators of sexual abuse, and to encourage early disclosure.
b. Embed best practice early intervention responses that target presenting symptoms and potentially minimise the likelihood that someone might go on to develop a more serious/entrenched mental illness.

c. Build in flexibility of service and system design to ensure service providers are able to provide an ongoing service where required and strengthen capacity to work collaboratively with professionals across different sectors (i.e. mental health, CASA, etc.) with the client's needs and voice at the centre.

Research and evaluation

a. Invest in research into best practice interventions that facilitate recovery for victims of sexual assault, and that prevent the onset of mental ill-health.
b. Ensure research is grounded in methods that privilege the voices and experiences of those who have lived through child sexual abuse/sexual assault.
c. Prioritise the evaluation of methodologies that bear witness to the experiences of children, young people and adults and their families, that are more likely to counter the impacts of silencing and invalidation that not only accompany experiences of sexual abuse, but can be a significant part of the experience of mental illness.

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REFERENCES

Anda, R., V. Felitti, J. Bremner, J. Walker, C. Whitfield, B. Perry, S. Dube and W. Giles (2005). "The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology." European Archive of Psychiatry and Clinical Neuroscience **256**(3): 174-186.

Anda, R., V. Felitti, J. Bremner, J. Walker, C. Whitfield, B. Perry, S. Dube and W. Giles (2006). "The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology." European Archive of Psychiatry and Clinical Neuroscience **256**(3): 174-186.

Anda, R. F., D. Brown, V. Felitti, J. Bremner, S. Dube and W. Giles (2007). "Adverse childhood experiences and prescribed psychotropic medications in adults." American Journal of Preventive Medicine **32**(5): 389-394.

Andrews G, et al (2004) Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. Vol. 2. Geneva: World Health Organization, 1851–940.

Angelakis, I., E. Gillespie and M. Maria Panagioti (2019). "Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis." Psychological Medicine **49**: 1057-1078.

Australian Bureau of Statistics (2013). The Personal Safety Survey 2012. Canberra: ABS

Australian Bureau of Statistics (2015). Recorded Crime- Offenders 2013-2014. Canberra: ABS

Australian Bureau of Statistics (2017). The Personal Safety Survey 2016. Canberra: ABS

Australian Institute of Health and Welfare (2019). Family, domestic and sexual violence in Australia: continuing the national story. Canberra, AIHW.

Australian Institute of Health and Welfare (2007) Begg et al. The burden of disease and injury in Australia 2003, Canberra: AIHW

Berkowitz SJ, Stover CS, Marans SR. (2011). The child and family traumatic stress intervention: secondary prevention for youth at risk of developing PTSD. Journal of child psychology and psychiatry, and allied disciplines. 52. 676-85.

Bloom, S. (2019). Trauma theory. Humanising mental health care in Australia. A guide to trauma-informed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge**:** 3-30.

Bowlby, J. (1969). Attachment and loss: volume 1. London, The Hogarth Press and the Institute of Psycho-Analysis.

Brewin, C. (2011). "The nature and significance of memory disturbance in Posttraumatic Stress Disorder." Annual Review of Clinical Psychology **7**: 203-227.

Briere, J. (1992). Child abuse and trauma: Theory and treatment of the lasting effects. Newbury: USA, Sage.

Briere, J. and C. Jordan (2004). "Violence against women: outcome complexities and implications for assessment and treatment." Journal Of Interpersonal Violence **19**(11): 11252-11276.

Brown, L. (2004). "Feminist paradigms of trauma treatment." Psychotherapy: theory, research, practice, training **41**: 464-471.

Brown, L. (2019). "Feminist therapy." Retrieved 14/06/2019, 2019.

Child Safety Commissioner (2009). From isolation to connection. A guide to understanding and working with traumatised children and young people. C. S. Commissioner. Melbourne, State of Victoria.

Coles, J., A. Lee, A. Taft, D. Mazza and D. Loxton (2015). "Childhood sexual abuse and its association with adult physical and mental heatlh: Results from a national cohort of young Australian women." Journal of Interpersonal Violence, **30**(11): 192444.

Courtois, C. and D. Ford (2019). Sequenced relationship-based treatment for complex traumatic stress disorder. Humanising mental health care in Australia. R. Benajamin, J. Haliburn and S. King. New York, Routledge**:** 211-222.

Cozolino, L. (2002). The interpersonal sculpting of the social brain. The neuroscience of psychotherapy: healing the social brain. Cozolino. New York, Norton.

Curry-Stevens, A., Anti-Oppressive Practice (2016) Oxford Bibliographies

Cusack, K., B. Frueh, T. Hiers, S. Suffoletta-Maierle and S. Bennett (2003). "Trauma within the psychiatric setting: A preliminary empirical report." Administration and Policy in Mental Health **30**: 453-460.

Cutajar M, Mullen P, Ogloff J, Thomas S, Wells D and Spataro J (2010). "Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study. ." The Medical Journal of Australia **192**: 184–187.

Doidge, N. (2017). The brain changes itself. New York, Viking.

Dominelli, L. (2009). *Anti-oppressive practice: the challenges of the twenty-first century*. In R. Adams, L., Dominelli & M., Payne (Eds.), Social work: themes, issues and critical debates, 3rd edition. Basingstoke, UK: Palgrave Macmillan.

echo (2018). "What do I do?" Trauma-informed support for children. Los Angeles, USA, echo.

Elliot, D., P. Bjelajac, R. Fallot, L. Markoff and B. Reed (2005). "Trauma-informed or trauma-denied: principles and implemenation of trauma-informed services for women." Journal of Community Psychology **33**(4): 461-477.

Felitti, V., R. Anda, D. Nordenberg, D. Williamson, A. Spitz, V. Edwards, M. Koss and J. Marks (2019). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine **56**(6): 774-786.

Fleming JM (1997) Prevalence of childhood sexual abuse in a community sample of Australian women. Medical Journal of Australia, 166:65–68.

Gal, G., I. Levav and R. Gross (2012). "Child/adolescent abuse and suicidal behavior: are they sex related? ." Suicide and life-threatening behavior **42**: 580–588.

Gaskill, R. and B. Perry (2012). Child sexual abuse, traumatic experiences, and their impact on the devloping brain. Handbook of child sexual abuse, identification, assessment, and treatment. P. Goodyear-Brown, Wiley & Sons**:** 1-28.

Gold S, Hughes D, Swingle J (1996) Characteristics Of Childhood Sexual Abuse Among Female Survivors In Therapy, Child Abuse & Neglect, Vol. 20, No. 4, pp. 323-335. 1996

Haskel, L. (2012). A developmental understanding of complex trauma. Becoming trauma informed. N. Poole and L. Greaves. Toronto, Centre for Addiction and Mental Health**:** 9-27.

Heenan, M., & Murray, S. (2007). Study of reported rapes in Victoria 2000-2003. Summary research report. Melbourne: Statewide Steering Committee to Reduce Sexual Assault.

Herman, J. (1992). Trauma and recovery. The aftermath of violence-from domestic abuse to political terror. New York, Basic Books.

Herman, J. (2017). Trauma and recovery. The aftermath of violence-from domestic aubse to political terror. New York, Basic Books.

Herman, J., C. Perry and B. van der Kolk (1989). "Childhood trauma in borderline personality disorder." American Journa of Psychiatry (146).

Jennings, A. (2004). Models for developing trauma-informed behavioral health systems and trauma specific services. Rockville, Maryland, USA, SAMHSA & NASMHPD

Johnstone, S., M. Boyle, J. Cromby, J. Dillon, D. Harper, P. Kindermann, E. Longden, D. Pilgrim and J. Read (2018). The Power Threat Meaning Framework. Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester, UK, The British Psychological Society.

Kate, M. and M. Dorahy (2019). Complex Post-Traumatic Stress Disorder, Developmental Trauma Disorder, Borderline Personality Disorder, and the Dissosiative Disorders. Humanising mental heatlh care in Australia. A guide to trauma-infromed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge**:** 84-97.

Kezelman, C. (2019). Childhood trauma-the long-term impact and the human cost. Humanising mental heatlh care in Australia. A guide to trauma-informed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge.

Kezelman, C. and P. Stavropoulos (2012). The last frontier. Practice guidelines for treatment of complex trauma and trauma-informe care and service delivery. . Sydney, Blue Knot Foundation.

Kezelman, C. and P. Stavropoulos (2017). Talking about trauma: guide to everyday conversations for the general public. Sydney, blue knot foundation.

Kezelman, C. and P. Stavropoulos (2018). Talking about trauma: guide to conversations and screening for health and other service providers. Sydney, blue knot foundation.

Khalihef, H., M. P., R. Borschmann, K. Dean, C. Hart, J. Hogg, D. Orborn, S. Johnson and L. Howard (2014). "Domestic and sexual violence against patients with severe mental illness." Psychological Medicine **45**(875-86): 875-886.

Kilroy, D. (2000). When Will You See The Real Us? Women In Prison. Sisters Inside Inc. Queensland.

Kisiel, C. and J. Lyons (2001). "Dissociation as a mediator of psychopathology among sexually abused children and adolescents." American Journal of Psychiatry **158**(7): 1034-1039.

Klinic Communty Health Centre (2013). Trauma informed : the trauma toolkit. Manitoba, Canada.

Kobak, R. and G. Bosmans (2019). "Attachment and psychopathology: a dynamic model of the insecure cycle." Current Opinion in Psychology **25**: 76-80.

Krawitz, R. and C. Watson (2000). Borderline Personality Disorder: foundations of treatment. Melbourne, Spectrum. Personality Disorder Service for Victoria.

Lanthier, S., J. Du Mont and R. Mason (2018). "Responding to delayed disclosure of sexual assault in health settings: A systematic review." Trauma, Violence & Abuse **19**(3): 251-265.

Lalor, K., McElvaney, R. (2010) Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs in Trauma, Violence and Abuse.

Mamun, A. A., Lawlor, D. A., O'Callaghan, M. J., Bor, W., Williams, G. M. and Najman, J. M. (2007). Does childhood sexual abuse predict young adult's BMI? A birth cohort study. Obesity 15 (8) 2103-2110

McPhail, B. (2016). "Feminist framework plus: knitting feminist theories of rape etiology into a comprehensive model." Trauma, Violence & Abuse **17**(3): 314-329.

Meares, R. (2019). The human brain-mind system. In: Humanising mental health care in Australia. A guide to trauma-informed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge: 31-42.

Mental Health Coordinating Council (2018). Trauma Informed Care Toolkit. Sydney, MHCC.

Middleton, W., M. Dorahy and A. Moskowitz (2008). Historical concepts of dissociation and psychosis: nineteenth and early twentieth century perspectives on severe psychopathology. Psychosis, trauma and dissociation: emerging perspectives on severe psychopathology. A. Moskowitz, A. Schafer and M. Dorahy. Oxford: UK, John Wiley & Sons: 9-20.

Mouzos, J. and T. Makkai (2004). Women's experience of male violence, findings from the Australian component of the International Violence Against women survey. A. I. o. Criminology. Canberra, Australian Institute of Criminology.

Mueser, K., L. Goodman, S. Trumbetta, S. Rosenberg, F. Osher, R. Vidaver, P. Anciello and D. Foy (1998). "Trauma and Posttraumatic Stress Disorder in severe mental illness." Journal of Consulting and Clinical Psychology **66**: 493-499.

Mullen, P., J. Martin, J. Anderson, S. Romans and G. Herbison (1993). "Childhood sexual abuse and mental health in adult life." British Journal of Psychiatry **163**: 721-732.

Newmann, L. (2019). Trauma-informed care in infancy. Humanising mental health care in Australia. A guide to trauma-infroed approaches. R. Benajamin, J. Haliburn and S. King. New York, Routledge.

Perry, B. (2013). Bonding and attachement in maltreated children. Consequences of emotional neglect in childhood.

Perry, B., R. Pollard, T. Blakely, W. Blaickley and D. Vigilante (1995). "Childood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: how "states' becomes "traits"." Infant Mental Health Journal **16**(4): 271-291.

Plunkett, A., B. O'Toole and H. Swanston (2001). "Suicide risk following child sexual abuse." Ambulatory Pediatrics **1**(5): 262-266.

Poole, N. and L. Greaves, Eds. (2012). Becoming Trauma Informed. Toronto, Centre for Addiction and Mental Health.

Quadara, A. and C. Hunter (2016). Principles of trauma-informed approaches to child sexual abuse: a discussion paper. Melbourne, Royal Commission into Institutional Responses to Child Sexual Abuse.

Rao, S. and J. Beatson (2019). Developing a state-wide servie for the treatment of patients with Borderline Personality Disorder. Humanising mental heatlh care in Australia. A guide to trauma-informed approaches. R. Benjamin, J. Haliburn and S. King. New York, Routledge: 367-379.

Read, J., R. Fosse, A. Moskowitz and B. Perry (2014). "The traumagenic neurodevelpomental model of psychosic revisited." Neuropsychiatry **4**(1): 65-79.

Read, J., L. Goodman, A. Morrison, C. Ross and V. Aderhold (2004). Childhood trauma, loss and stress. Models of madness. Psychological, social and biological approaches to schizophrenia. J. Read, R. Loren, L. Mosher and R. Bentall. East Sussex: UK, Routledge.

Read, J., P. Hammersley and T. Rudegeair (2007). "Why, when and how to ask about childhood abuse." Advances in Psychiatric Treatment **13**: 101-110.

Read, J., D. Harper, I. Tucker and a. Kennedy (2018). "Do adult mental health services identify child abuse and neglect? A systematic review." Mental Health Nursing **27**: 7-19.

Read, J., K. McGregor, C. Coggan and D. Thomas (2006). "Mental health services and sexual abuse: The need for staff training." Journal of Trauma & Dissociation **7**(1): 33-50.

Read, J., J. Os, A. Morrison and C. Ross (2005). "Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinicial iimplications." Acta Psychiatrica Scandinavia **112**(5).

Read, J., B. Perry, A. Moskowitz and J. Connolly (2001). "The contribution of early traumatic events to schizophrenia in some patients: a traumagenic neurodevelopmental model." Psychiatry **64**(4): 319-345.

Reynolds, V. (2013). Justice-Doing at the intersection of power. Adelaide, Dulwich Centre.

Reynolds, V. and S. Hammoud-Beckett (2018). Social justice activism and therapy: tensions, points of connection and hopeful sceptcism. Social justice and counselling. C. P. Audet, D.,. NY, Routledge.

Richmond, K., E. Geiger and C. Reed (2013). "The personal is political: a feminist and trauma-informed therapeutic approach to working with a survivor of sexual assault." Clinical Case Studies **12**(6): 443-456.

Royal Commission into Institutional Responses to Child Sexual Abuse (2017). Final Report: Volume 4, Identifying and disclosing child sexual abuse Commonwealth of Australia, Canberra.

Runtz M (2002) Health Concerns of University Women With a History of Child Physical and Sexual Maltreatment, Child Maltreatment, Vol. 7, No. 3, August 2002 241-253

SAMHSA (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville, USA, Substance Abuse and Mental Health Services Association.

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia: Melbourne.

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Victorian Centres Against Sexual Assault

Tyler K and Cauce A-M (2002) Perpetrators of early physical and sexual abuse among homeless and runaway adolescents, Child Abuse & Neglect 26 (2002) 1261–1274

Victorian Crime Statistics Agency, (2017) Sexual Offences in Victoria 2016. Crime Statistics Agency, Melbourne. https://www.crimestatistics.vic.gov.au/media-centre/news/sexual-offences-in-victoria-0