Current approaches to preventing and responding to sexual assault: A Rapid Evidence Assessment

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Introduction

Purpose of review

This review examines the Australian and international literature around sexual violence prevention, education, crisis and long-term support, policing and legislative responses, and training and capacity building. We undertook a systematic rapid evidence review of the relevant literature to identify innovation and best practice in four key domains:

1. Prevention and education strategies to change the attitudes and behaviours that lead to sexual assault and other forms of violence against women;
2. Crisis as well as long-term medical, psycho-social, cultural, therapeutic and healing support for victims/survivors;
3. Policing responses to both victims and perpetrators, legislation and effective interventions for perpetrators;
4. Trauma-informed training, development and capacity-building models to enable services to deliver sustainable and appropriate support.

The review aimed to understand “what works” in these four areas and to provide critical insights and policy learning for possible application within the NSW context.

Current context

Sexual violence against both children and adults affects a large number of Australians (Australian Institute of Criminology [AIC], 2015; Tarczon & Quadara, 2012). Although a crime that primarily affects women and girls, boys and men are comprise a large minority of victim/survivors (Tarczon & Quadara, 2012). Victimisation in either childhood, adulthood or both can lead to a range of negative impacts (psychological, emotional, physical and sexual) that the individual can experience over their life-course, such as post-traumatic stress disorder, alcohol and other drug dependency, relationship breakdowns, chronic physical ailments, and ongoing anxiety, amongst many other conditions (Cashmore & Shackel, 2013). Female victim/survivors of child sexual abuse (CSA) may have different therapeutic and non-therapeutic treatment needs than males (Alaggia & Millington, 2008; Boyd, 2011; Burke Druaker, 1999; Price-Robertson, 2012), and victim/survivors of CSA may have different treatment and support needs to adult (female and male) victim/survivors of adult sexual assault and violence (Burke Druaker, 1999; Morrison, 2007).

The recognition of the ongoing effects of sexual violence on the individual has resulted in increased research focus on the types of crisis and long-term support that victim/survivors receive (Decker & Naugle 2009; Harvey & Taylor, 2010), examining whether legislative and criminal justice responses are appropriate (Pearce, 2014), observing how sexual assault service, police, and medical personnel can respond to sexual assault disclosure suitably to prevent re-victimising the victim/survivor (McElvaney, 2015), and focusing on how sexual violence can be prevented from occurring (Finkelhor, 2009; Ogloff & Cutajar, 2014). Researchers also recognise that services require individualisation for victim/survivors from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander communities (Allimant & Ostapiej-Piatkowski, 2011; NSW Ombudsman, 2012).

In sum, over the last 10-15 years, studies across a range of disciplines and populations have increasingly cohered to demonstrate that that sexual victimisation (such as child sexual abuse and sexual assault) is prevalent, results in significant collective harm to individuals, families, and the community and that far from being an intractable social fact, there are a range of risk factors that can be modified to prevent sexual violence from occurring in the first place (WHO, 2002; VicHealth
Against this backdrop, there is an increased motivation to develop, implement, evaluate and monitor strategies that result in sustainable, whole of population change to prevent violence before it occurs.

**Method**

This rapid evidence review accessed peer-reviewed articles, books, grey literature and policy documents that were identified as being relevant and within the agreed upon parameters of the search, namely:

- the search was limited for resources published between 2005 and 2016
- literature from Australia was prioritised, however literature from the US, UK, Canada, Ireland and New Zealand was also sought out;
- literature that presented a meta-analysis was prioritised;
- the literature dealt exclusively with sexual violence and/or CSA, and
- literature that was evaluations of or presented programs identified as being “best practice” in the field of sexual assault and CSA.

An EndNote library was created in which the references of the relevant literature were included. Over 100 documents were identified, accessed and compiled into this reference library. This library includes grey literature (for example, evaluations of educational programs funded by government departments), and theses references. The number may appear low but that was due to strict adherence to the search parameters, especially the last point of seeking out documents that present “best practice” programs with regards to sexual violence and CSA prevention.

Documents that were not included into the EndNote reference library included the evaluations of programs or discussion of research concerned with domestic and family violence. Although CSA is predominantly perpetrated by individuals known to the child, especially family members (Tarczon & Quadara, 2012; Quadara et al., 2015), and individuals who are suffering domestic and family violence may also experience sexual assault from their partner, the literature about these programs and services were often unclear about to what extent CSA and sexual violence are dealt with or in what manner. Due to the dynamics and risk factors for CSA and sexual violence, while there is an overlap between sexual crimes against adults and children and domestic violence, researchers often differentiate between domestic violence and sexual crimes, even if those crimes have been committed by family members (Cox, 2015). Research indicates that interventions for sexual crimes against adults and children, and risk factors for victimisation and perpetration differ to domestic violence interventions and risk factors (Cox, 2015). Therefore, attention was focused on evaluations, reports and research literature that dealt exclusively with sexual violence against children and adults.

An initial list of search strings based on appropriate key words was drawn up. The initial list included 40 search strings such as “best practice AND education AND sexual assault”, “services AND training AND child sexual abuse”, and “trauma-informed AND training AND sexual assault AND services”. Search strings and key words were modified as necessary. For instance, the term “best practice” would often return results in grey literature but not in peer-reviewed research literature, however the key word “effective” or “evidence” would return results in peer-reviewed literature but not in grey literature. The main keywords initially used to build the search strings were:

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Numerous databases were searched for relevant peer-reviewed articles including EBSCO Social Science database, ProQuest, InformIT, and PubMed. Grey literature, policy documents, and the names of services and programs were sourced via Google and Google Scholar searches using the search strings and key words.
**Terminology**

The terminology employed in this review attempts to be inclusive of the various ways in which individuals may experience child sexual abuse and sexual violence victimisation in adulthood. It has been previously noted that there is no one clear definition for either child sexual abuse or sexual violence (Quadara, Nagy, Higgins, & Siegel, 2015). Broader definitions of both CSA and sexual violence have been utilised in this review as government policy documents, sexual assault service, and research reports all tend to vary in their definitions with various limitations on their definitions of either crime.

**Child Sexual Abuse**

Definitions of child sexual abuse are often conservative and narrow due to the reliance on legal definitions of sexual abuse against children. This also results in fragmented definitions as within Australia there are no uniform laws or legal definitions of sexual abuse of minors, and while all Australian jurisdictions recognise individuals under the age of 18 years as children, child sexual abuse does not automatically equate to the sexual abuse of those aged under the 18 years. For instance, in Victoria child sexual abuse can only be perpetrated against those under the age of 16 years, whereas in New South Wales child sexual abuse can be perpetrated against those under the age of 18 years.

The use of research literature alone (primarily those appearing in peer-reviewed academic publications) to define CSA in a review of this kind raises concerns due to the limitations used in academic literature to define sexual abuse. These definitions often do not include certain behaviours as sexual abuse or exploitation (for example, non-contact, online sexual abuse or grooming), or define perpetration as only possible from adults, specifically individuals aged at least 18 years old or above (thereby excluding sexual abuse perpetrated by adolescents).

The definition of child sexual abuse that is broad in defining potential victims, perpetrators and sexually abusive acts is based on the public health model used by the World Health Organization (WHO). WHO (1999) defines child sexual abuse as:

> The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:
>  
> • the inducement or coercion of a child to engage in any unlawful sexual activity;
>  
> • the exploitative use of a child in prostitution or any unlawful sexual activity;
>  
> • the exploitative use of a child in a pornographic performance and materials. (p. 62)

As part of this research, the WHO definition of CSA was used when searching for literature due to its broad nature.

**Sexual Assault and Violence**

As with child sexual abuse, the definitions of sexual assault and sexual violence are fragmented. However, sexual violence is generally accepted as a broad term that includes all manner of unwanted and coerced sexual contact and behaviour, with sexual assault an act incorporated under this broad term that is also often referred to as rape. Within Australia, several jurisdictions refer to penetrative sexual offences as rape (Victoria, Queensland, South Australia and Tasmania), or sexual assault (New South Wales), sexual intercourse without consent (ACT and Northern Territory), or sexual penetration
without consent (Western Australia) (Australian Law Reform Commission [ALRC], 2010). Non-penetrative sexual acts without consent can be referred to as indecent assault (NSW, Victoria). Differences in how penetration, consent, and aggravating factors are defined means that there is no one legal definition in Australia about what constitutes as sexual assault or sexual violence. The National Plan to Reduce Violence Against Women and Their Children 2010–2022 defines sexual assault and violence to include ‘rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with the friends of the perpetrator’ (Council of Australian Governments [COAG], 2011, p. 2).

As with CSA, sexual assault and violence are not clearly defined terms in academic research either, and often are narrowed down to the focus of the research paper. Therefore this review used the definition of sexual violence from the Center for Disease Control and Prevention (CDCP). The CDCP defines sexual violence

A sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; nonphysically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim engage in sexual acts with a third party. (Basile, Smith, Breiding, Black & Mahendra, 2014, p. 11)

In this rapid evidence review “rape” and “sexual assault” are used interchangeably to describe any forced or unwanted sexual contact including penetration, fondling or molestation of an individual. The term “sexual violence” is used in this review to describe any unwanted sexual experiences including sexual assault but also unwanted exposure to pornography or other sexual situations, verbal sexual harassment, or dissemination of sexual or sexualised recordings or photographs (this is not an exhaustive list).

Prevention

The World Health Organisation (WHO) and the Centers for Disease Control (CDC) define primary prevention as preventing violence before it occurs, and there are Australian organisations that also use this definition in relation to sexual assault (Kwok, 2007). For the purposes of this review, the WHO and CDC definition is used for assessing if the literature is concerned with preventing CSA and sexual violence. Literature (and programs) that are concerned with preventing recidivism or eliciting disclosures from children and adults who have been victimised will be referred to as tertiary interventions. This is in reference to the public health model that conceptualises three levels of prevention: primary (preventing violence before it occurs on a broad, societal-wide level), secondary (identifying those at risk of either perpetrating sexual violence or those at risk of victimisation and intervening with those specific individuals or groups), and tertiary (responses after the violence has occurred).

Socio-ecological model

Sexual assault and child sexual abuse services in Australia often conceptualise the responses to victim/survivors, and education about prevention of sexual violence within the socio-ecological model in conjunction with the public health model. The socio-ecological model (developed by Bronfenbrenner (1977)) describes the interrelatedness of different spheres of social life and environment that an individual can interact with on a daily basis. Within this theory there are

- individual influences to victimisation or perpetration of sexual violence and abuse (factors that are dependent on the history of the individual),
- interpersonal influences (factors that are dependent on peers, family members, friends and their interaction with the individual),
• community influences (factors associated with organisations e.g. schools, that an individual
  may interact with and gain influences on their behaviour), and
• societal influences (large, structural factors of government and laws that influence community
  and individual behaviours, for example gender inequality or religion).

This literature review has also considered the socio-ecological model as part of the literature search
and will be using the terminology associated with this model in presenting the findings.

**Structure of this report**

This report has two sections. **Section A** contains implications and recommendations drawn from the
Rapid Evidence Assessment to inform:

• Prevention and education of sexual abuse and assault
• Crisis and long-term support services for victim/survivors and non-offending family members
• Legislative responses for victims and perpetrators of sexual abuse and assault; and
• Trauma-informed training and capacity building for support services

**Section B** is a more comprehensive document. It provides the findings of our Rapid Evidence
Assessment of the four domains above, and presents current practice and evidence in relation to child
sexual abuse and adult sexual assault from Australia and internationally.
SECTION A: IMPLICATIONS ARISING FROM THE REVIEW OF THE EVIDENCE

Overview

Sexual violence against children and adults can take a range of forms such as:
- child sexual abuse perpetrated by adult relatives, carers and guardians in intrafamilial, extrafamilial or community settings;
- sexually abusive or coercive behaviour by other children and adolescents in intrafamilial, extrafamilial or community settings;
- the production, dissemination or collection of child/adolescent exploitation material;
- sexual exploitation of adolescents;
- sexual assault in adolescent peer romantic/dating relationships; and
- sexual assault of adults in a range of professional, friendship, romantic, sexual and intimate relationships.

While sexual violence takes a range of forms and occurs in diverse contexts, it is important to note several common dynamics:
- the vast majority of sexual violence is perpetrated by someone with whom the victim/survivor has a relationship of some kind – familial, professional, guardianship, peer, or casual (ABS 2016; Tarczon & Quadara 2012);
- sexual violence is significantly gendered, particularly in terms of perpetration, with available research suggesting approximately 85-95% of sexual offences are perpetrated by males (Statopoulos, 2014);
- victims of sexual violence either delay disclosing their experiences at the time or report that their attempts at disclosure are unacknowledged, dismissed or disbelieved (Alaggia, 2004; 2005; 2010; Lievore 2005);
- social attitudes to sexual violence such as child sexual abuse and sexual assault have historically stigmatised or blamed victims for their victimisation and community understanding of the circumstances, dynamics and consequences of sexual violence is weak (Cossins, 2008; Flood, 2009; Ullman 2002); and
- most sexual offences are significantly underreported and difficult to successfully prosecute (Daly & Bourhours 2010; Quadara, 2014).

Significant efforts have been made to prevent and respond to these forms of sexual victimisation and to address the above dynamics. However, it remains the case that policy development and service responses are often fragmented or uncoordinated. Perhaps the clearest example of this is the division in policy responsibility between child and adult forms of sexual victimisation, with the former largely located within a child protection framework while adult sexual assault is most commonly the province of health or women’s policy areas. This creates disjunction in understandings in relation to causes, prevention approaches and the most appropriate way of responding to—and preventing—perpetration. It can also mean that some populations – for example, adolescents sexually assaulted by a peer or romantic partner, older people, or those requiring supported care – can “fall through the gaps” of current policy frameworks, prevention strategies and service responses.

In regard to sexual abuse more specifically, it is not clear that it has a coherent conceptual or policy “home”. As noted by Quadara and colleagues (2015), as a social and policy issue, child sexual abuse crosses at least four domains: child protection, criminal justice and correctional systems, violence against women, and family wellbeing and support (including health/medical systems). For example:
- sexual abuse that occurs within the family environment is located within a child protection framework only where it is deemed that there is no capable, protective guardian;
• non-familial child sexual abuse often falls within the realm of police as first/main responders rather than child protection (noting that some jurisdictions have formalised co-investigatory/response protocols between police and child protection authorities);
• sexual violence perpetrated by adolescents may be considered as an issue of either child safety/child protection approaches and within a violence against women framework;
• consequences of child sexual abuse can often require navigation of multiple health and medical support systems (and might trigger mandatory reporting obligations, which in turn involve statutory child protection authorities).

This can mean not only different approaches to prevention of sexual abuse, but also a risk that child sexual abuse falls between the gaps of key policy frameworks, particularly between those dealing with sexual violence against adults and those concerned with child safety and child protection.

In Part A, we draw on the evidence set out in Part B to outline:
• implications of the evidence reviews for Domains 1-4; and
• fundamental principles of a sexual assault prevention and response strategy to address the challenges presented in the review.

The next section outlines the main findings of the review and the implications for the development of a state-wide sexual assault strategy in relation to ‘what works’ what doesn’t as well as challenges to be addressed for each of the four domains.

Implications of the evidence review within each domain

Domain 1: Prevention and education

As noted earlier preventing sexual assault and child sexual abuse before they occur (i.e., primary prevention) is a key priority. To this end, there has been significant effort given to conceptualising primary prevention and prevention education with young people and adults. Overall, the field in sexual assault prevention is conceptually robust and, having developed and implemented a number of best practice programs in diverse settings, is at the stage of testing the underlying principles and theories of change about what works and why in prevention and education efforts.

Below, we highlight the key messages arising from the evidence review for both adult sexual assault and child sexual abuse.

Adult sexual assault

• The primary prevention of adult sexual assault is conceptually a well-developed field and is moving to testing its underlying assumptions.
• Prevention education in the form of programs to educate adults about the underlying causes of sexual violence are presented in a variety of settings and include the following elements:
  • Tried and tested – programs must be evaluated (evidence of trial, modification and effectiveness should form the basis of continued trial, scaling up and broader implementation);
  • Robust theory of change;
  • A focus on the structural factors that underlie sexual violence;
• Inclusivity – a shared understanding that men have a positive role to play in the prevention of sexual violence.

Challenges

There are a number of challenges facing primary prevention and education efforts:

• Maintaining policy momentum and commitment to the long-term social change effort that primary prevention aims to achieve. Other public health campaigns such as road safety or smoking reduction have worked on seeing change over a 10-15 year time frame. It can be
difficult for policy makers and funders to commit to initiatives that are not seen to make a “difference” within a 1-2 year time frame.

- **Expanding prevention programs, evaluation and learning beyond education settings.** Evaluated, evidence based programs are predominantly respectful relationship programs with young people in schools. There has arguably been less:
  - programmatic effort given to prevention with young people not in school settings or in other settings such as organisations and workplaces, the media or primary health (e.g., maternal and child health);
  - exploration of how “macro” policies in employment, superannuation, income support childcare, and so on can or do currently contribute to, and reinforce prevention strategies that target interpersonal and community levels of the social ecology.
- **A chasm between primary prevention work with men and tertiary responses to perpetrators.** There does not appear to be any bridge between universal, primary prevention work on respectful relationships and gender equity on the one hand, and tertiary sex offender treatment programs with convicted offenders on the other. Given only a very small proportion of perpetrators will ever be convicted, this leaves an alarming vacuum for possible intervention with men displaying problematic behaviours.

**Child sexual abuse**

- Efforts that aim to prevent sexual abuse from occurring in the first instance currently include:
  - “protective behaviours” or prevention education programs, which provide children with knowledge and strategies that would assist them in protecting themselves against abuse (these may also may also involve parents, and broader school personnel or systems); and
  - using situational crime prevention and/or organisational change principles to create child safe organisations and physical environments (Higgins, D. J., Kaufman, K., & Erooga, M. in press).
- Sexual abuse prevention education is not as well conceptualised or evaluated as prevention education for sexual assault:
  - there no consistent policies or guidelines regarding how child sexual abuse prevention is or should be taught to students, whether students’ knowledge, skills, confidence or actual use of the strategies should be assessed following the education, whether the teachers receive training, or even if parents should know that their children are being taught prevention strategies (Walsh et al., 2013);
  - More broadly prevention education in relation to CSA lacks consensus about what constitutes ‘best practice’ in design, implementation or duration of programs; the key ingredients of effective programs; and requisite skills of educators, and indeed who should provide this education (i.e., whether this is something teachers should do or something that dedicated specialists do).
- In relation to child-safe organisations, Australian institutions and organisations are not compelled by any legislation or incentives to introduce policies to prevent child sexual abuse. Outlines of optimal prevention strategies (usually 10-step strategies involving adults as well as children) have been created by the Canadian Red Cross, Smallbone et al.’s model, or Erooga et al (2012). Their efficacy is currently unknown, although evaluations are currently underway in Queensland. However, the recommendations of the Royal Commission into Institution Responses to Child Sexual Abuse are likely to be highly pertinent to this.
- Secondary/early intervention is a more developed field in child sexual abuse than primary prevention particularly with reference to addressing problematic sexual behaviours and sexually abusive behaviours which are addressed, where appropriate, through counselling with the child and non-offending family members.
Challenges

A recent review on conceptualising the primary prevention of child sexual abuse (Quadara et al., 2015) provides an up-to-date assessment of current approaches to preventing sexual abuse in Australia and the challenges that need to be addressed. These are:

- **Differing views about primary prevention.** While there is agreement that primary prevention is the “change goal”, the complex and multi-sectoral nature of child sexual abuse means divergent views and practices about what should be the prevention target, with many approaches called primary prevention could more accurately be classified as secondary or tertiary prevention.
- **Lack of clarity about how broader child maltreatment prevention efforts such as family support programs address sexual abuse.**
- **A dominant focus on individual and interpersonal risk factors.** Community, social and structural factors are not often addressed. Moreover, the diverse list of noted risk factors does not assist policy, services or educators to understand 1) which of these are the most salient or 2) what are the causes underpinning those factors (i.e., the key determinants).

Domain 2: Crisis and long-term support for victim/survivors

The provision of therapeutic services in Australia for crisis presentations and long-term support for victim/survivors of sexual assault is based on trauma-informed practice, which is dictated by principles of safety, and the understanding that service users may have a history of violence/victimisation. This supports services to avoid potentially re-victimising processes that may be experienced as distressing for victim/survivors. Although there are shared, general principles for trauma informed care and practice, it is unclear how these principles should be implemented in practice for different settings (Quadara, 2015). Other service systems in which victim/survivors may find themselves (for example: financial, housing, GPs, gambling, employment) have an uneven understanding and application of trauma-informed principles which may be due to lack of resources or confidence in dealing appropriately with victim/survivors. Many sectors that may need to respond to victim/survivors are diverse and may work from different ideological perspectives.

Key observations are:

- The concept of interagency collaboration to provide a holistic service response to victim/survivors is exemplified by the Multi-Disciplinary Centers (MDC) in Victoria which bring together Victoria Police, child protection, and sexual assault counselling. The service providers in these hubs work together to support child and adult victims. The purpose of the co-location is to prevent victims from falling through the gaps between agencies and service providers who may be geographically dispersed or complex to traverse. There is an MDC evaluation currently underway in Victoria.
- The location of sexual assault services in or in close proximity to hospitals supports crisis presentations.
- There is little known about the long-term support needs of adult survivors of child sexual abuse and currently service systems may not be funded to support long-term support. A forthcoming research report to the Royal Commission into Institutional Responses to Child Sexual Abuse highlights the need for therapeutic and non-therapeutic supports such as:
  - Employment support
  - Access to financial and legal support
  - Uncapped access to counselling that is accessible over the life course as key life events such as first relationships, parenthood and having children may create the need to dip into and out of support services (Quadara, Stathopoulos & Carson, 2016).
- The needs of minority populations are not always well served in mainstream services and approaches to these groups requires flexibility as the needs of minority populations may be quite unique in relation to how services are to be delivered. A challenge in this context remains in approaches to incorporating minority population needs into a universal approach to prevent and respond to sexual violence.
Challenges

- Lack of funding remains a challenge. Services are currently providing case management services, referral, secondary consultation, therapeutic and non-therapeutic support and long-term support to complex presentations:
  - Waiting lists are both a function of a lack of resources, and the result of high demand. The complexity in supporting people with complex trauma and complex needs may put additional pressure on sexual assault services.
  - Sexual assault services are not always funded to provide counselling and support to non-offending family members or they may only be able to provide limited services. This is a gap in the service landscape.
- Services aimed at specific populations require further evaluation to bolster the evidence base for ‘what works’.
- Support mechanisms for potential child sexual abuse offenders are absent in Australia. In terms of treatment, the only option for these people is private practice. This lack of support pathway for potential offenders means the system is only geared to attend to their issues once they have offended.

Domain 3: Policing and legislative responses to victim/survivors and perpetrators

Currently, multiple statutory bodies are responding to victims of child and adult sexual assault. The need for broad and on-going sexual assault law reform education for both legal and non-legal actors is imperative (Bluett-Boyd & Fileborn, 2014). Some effective practices in these areas are outlined below.

- Multi-Disciplinary Centers (MDC) in Victoria are being rolled out, which house Victoria police alongside child protection and sexual assault counselling.
- Victoria Police are trialing/implementing the ‘Whole Story’ approach to investigating sexual assault crimes.
- Reform of sexual assault laws have occurred in some jurisdictions to provide less traumatising experiences for victim/survivors giving evidence in court including:
  - allowing vulnerable victims to give evidence remotely;
  - providing a non-legal therapeutic support person to accompany the victim/survivor; and
  - directions to the jury advising that long periods between abuse and reporting do not diminish the victim/survivors credibility (Bluett-Boyd & Fileborn, 2014);
- Innovative and alternative forms of justice, such as restorative justice practices and judicial information sharing systems require evaluation, beginning with a focus on systems, have shown some promise in implementation and delivery (ideally all such initiatives should include provisions for evaluation in the design stage).
- Current offender treatment programs in prison for sexual violence offenders use a Cognitive Behaviour Therapy approach. A promising practice in this area are strengths based models which seek to enhance pro-social behavior and esteem. The Good Lives Model is a good example of this.
- There has been a shift in focus from investigating sexual offender recidivism to looking at desistance, particularly seeking to identify attributes, factors and effective correctional intervention to promote desistance from offending. However, desistance research is in its infancy and requires attention in order to build a strong evidence base.

Challenges

- Regardless of sexual assault reforms, victim/survivors are still experiencing court as re-victimising. The question of how much can be done to ameliorate this is ongoing. For example, there is a difficulty in separating the therapeutic and legal needs of victim/survivors and a question about how appropriate a legal context is for the provision of therapeutic needs.
• For adult victim/survivors of child sexual abuse there has not been a comprehensive multi-faceted research into police and legal response needs. This gap is receiving some attention for institutional and extra-familial abuse victims from the Royal Commission into Institutional Responses to Child Sexual Abuse.

Domain 4: Trauma-informed practice and capacity building for services

There is increasing awareness in child/family welfare and adult-focused specialist services on the need for, and value of trauma-informed approaches to practice.

• Promising practice in this area rests with sexual assault services in Australian states and territories and is informed by a more robust evidence base from the United States.

• There is a knowledge gap for services outside of the sexual assault sector and this rests on two factors – fear of doing harm, and diverse theoretical underpinnings of different service sectors including health and addiction services.

• There is a call to include an understanding of the causes and impacts of sexual assault at university level to address uneven service delivery across a range of sectors.

• Evaluation of trauma-informed services is required to support broader implementation and delivery.

Challenges

• A shared understanding of the necessary principles of trauma-informed practice has not yet been reached.

• Funding remains an issue in building the capacity of services to provide trauma-informed care. Similarly knowledge about where to access trauma-informed training means clear pathways for services will need to be established. For example, organisations such as Centres Against Sexual Assault (CASA) and Lighthouse Institute in Victoria provide training to a broad range of services in relation to trauma-informed practice.

Fundamental principles of a strategy to prevent and respond to sexual assault

Given the common dynamics noted previously, it is crucial to have a prevention and response strategy that addresses the diverse forms of sexual victimisation that occur over the life course to ensure that measures and initiatives are mutually reinforcing, or at the very least do not undermine each other.

To inform sexual assault policy development by Women NSW, we have identified three fundamental principles that a state-wide sexual assault strategy should be based on. These principles are informed both by the rapid evidence assessment on “what works” in preventing and responding to sexual assault (detailed in Part B) as well as the critical analyses and syntheses AIFS has published in relation to sexual assault. These principles are:

1. Sustainable, whole-of-population prevention requires a public health approach to addressing social harm, comprising:
   - a tiered approach to prevention (primary, secondary and tertiary strategies);
   - a socio-ecological understanding of the intersections between individual, relational and social influences;
   - a staged approach to problem definition, intervention, evaluation and scaling up.

2. “Gender inequality” is a central, though not the only, factor in understanding the diverse forms of sexual assault. Race, socio-economic status, ability, identity (sexuality & gender), and age are also important dimensions of power and inequality and, along with gender, need to be integrated into prevention strategies.

3. Systems and service responses need to be co-ordinated or “joined up” pathways integrating agencies with specialist knowledge of the dynamics and impacts of sexual assault and abuse with other therapeutic and non-therapeutic providers.
These key principles are examined below.

**A public health approach to violence prevention**

Landmark analyses on the economic and health costs of domestic violence (Access Economics, 2004; VicHealth 2004) along with global research on forms of violence (WHO 2002) ushered in a public health orientation to the prevention of sexual victimisation that built on and extended the existing evidence base developed since the 1980s on sexual assault and abuse.

A public health approach aims to provide the maximum benefit for the largest number of people and seeks to change the underlying behaviours and conditions that facilitate social harms. Its overall aim is to prevent the harm before it occurs the first time. It adopts a particular process for achieving this by:

- Defining the problem through the collection of information about the magnitude, scope, characteristics and consequences of sexual violence;
- Seeking to understand the underlying correlates (or “drivers”) of sexual violence, factors that increase or decrease risk for sexual violence, and factors that could be modified through interventions;
- Developing and testing prevention and intervention strategies;
- Evaluating strategies for effectiveness;
- Scaling up effective and promising strategies to a wide range of settings; and
- Evaluating impact and cost-effectiveness.

In Australia, there has been almost a decade of utilising public health concepts and strategies to prevent violence against women. While the empirical research base about “what works” is emergent, there is growing conceptual sophistication underpinning the work relating to how the following articulate:

- when prevention occurs;
- who initiatives are targeted at;
- what level of the social-ecology the initiative aims to influence (i.e., individual, family, community, society);
- the types of settings in which prevention occurs; and
- what drives behaviour change.

These concepts are briefly described in Table 1.

A key aspect of a public health approach for addressing sexual assault is the evaluation of programs, services, and interventions. The process of evaluation is crucial in understanding what is effective, what is promising and what is not. There can be no ‘scaling up’ of small programs for a broader social audience if there is no understanding of what elements are needed and what has been effective in a particular context, with a particular population. Evaluation knowledge will be the basis from which programs and processes are incorporated into a broader strategy to address sexual assault through therapeutic and legal mechanisms.

The benefits of drawing on a public health approach to prevention are:

- an emphasis on preventing violence before it occurs with the long-term goal of reducing the prevalence of sexual assault and abuse;
- aiming for population-level change rather than among individuals or groups;
- addressing the underlying conditions in society as a whole, as well as in particular community settings, that give rise to or enable sexual assault and abuse to occur; and
- recognition that initiatives need to be mutually reinforcing in order to drive and sustain change. This may be across the levels of prevention (i.e., justice responses reflect and reinforce messages about respectful relationships heard in prevention education) or across settings or levels of the social ecology.
This last point is particularly important as it enables a range of sectors, policy portfolios, organisations and industries to come together and work in an integrated way.

**Table 1 Key public health concepts**

<table>
<thead>
<tr>
<th>Key concepts</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Levels of prevention (the timing of initiatives)** | **Primary prevention** – This refers to strategies aimed at preventing assault *before* it occurs. It includes strategies aimed at tackling the underlying causes of sexual assault and abuse and bolster protective factors that promote pro-social behaviour such as respectful relationships.  
**Secondary prevention** (or early intervention) – This refers to programs that involve *early detection of risk* or early manifestations of the problem and the process of identifying risk for victimization and perpetration.  
**Tertiary prevention** (or response) – These are the *responses set in motion after sexual violence has occurred*. They aim to prevent or ameliorate the consequences and impacts of sexual violence and can include support and behavior change service systems, policing and criminal justice systems. |
| **Populations (the targets of initiatives)** | **Universal**: aimed at whole population;  
**Progressive universalism**: whole-of-population services or approaches with capacity to ramp-up and adjust the nature or intensity of service for those who need different or more intense services  
**Selected**: aimed at at-risk, vulnerable or high needs families and individuals;  
**Indicated**: aimed at identified victims or perpetrators. |
| **Socio-ecological domains of influence** | **Individual-level: microsystem**: Personal history factors that increase the likelihood of an individual becoming a victim or perpetrator of violence (e.g., factors such as alcohol and/or drug use, attitudes and beliefs that support violence, impulsive and other antisocial tendencies; hostility towards women; and a childhood history of sexual abuse or witnessing family violence).  
**Interpersonal relationship-level: exosystem**: Factors that increase risk as a result of relationships with peers, intimate partners, and family members. Peers, partners, and family members can reinforce attitudes and shape the individual's behaviour and range of experiences  
**Community-level: mesosystem**: Factors that increase risk based on community and social environments and inform an individual's experiences and relationships with schools, workplaces, and neighbourhoods.  
**Societal-level: macrosystem**: Larger, structural factors such as government policies or laws that influence attitudes and behaviours—for example, gender inequality, religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups of people. |
| **Settings** | This refers to diverse organisational, institutional and community locations to which specific prevention, early intervention and response initiatives are tailored, e.g.:  
- educational settings;  
- media and popular culture;  
- faith-based settings;  
- primary health settings;  
- child and youth-focused organisation  
- sporting clubs;  
- workplaces. |
| **Drivers of behaviour change** | Factors that foster, promote and maintain behaviour change i.e., fear, self-efficacy, social norms, attitudes, barriers, risks and rewards, intentions, skills competencies. |

Adapted from Quadara and Wall (2012)

**Gender and gender inequality**

Thirty years of research has demonstrated the deeply gendered nature of both sexual assault and child sexual abuse. More recently, public health strategies to prevent sexual violence in Australia (e.g.,
OurWatch, 2016; VicHealth, 2007) and internationally (CDC, 2004; WHO 2007) have identified the following as key determinants of sexual violence:

- Rigid gender roles and stereotyped constructions of masculinity and femininity;
- Beliefs, attitudes and social norms that condone violence against women;
- Male peer relations that emphasise aggression towards women and male sexual entitlement; and
- Unequal power between men and women in relation to decision-making, access to finance and employment.

Despite consistent findings nationally and internationally in relation to gendered patterns in sexual assault, there can be resistance to the idea that meanings, beliefs and social norms and practices are centrally relevant to sexual assault and sexual abuse on the basis that what is being suggested is that all men are (potentially) perpetrators instead of the contention that it is certain norms, beliefs and attitudes about what it is to be masculine or feminine that enables sexual assault and abuse to occur. Significant theoretical and empirical efforts have been made to conceptualise gender as a social rather than a biological or even psychological attribute. Common shorthand for this is to make a distinction between ‘sex’ and ‘gender’. ‘Sex’ is described as referring to the biological, physiological, and reproductive differences between men and women; whereas ‘gender’ refers to the social meanings attached to ‘male’ or ‘female’ (Victorian Health Promotion Foundation, Flood & Pease, 2006)

At the same time, there are conceptual challenges in understanding the role of gender in sexual victimisation. For example, the literature suggests:

- Women are the primary victims of sexual violence (ABS, 2013). However it is also relevant that men and boys comprise a substantial number of victims (ABS, 2013). It is also true that most perpetrators of sexual violence against women and men are men (ABS, 2013).
- Cognitive and intellectual impairment among offenders in the criminal justice system is a significant issue. It is not clear how gendered inequalities or male entitlement play a role for this group (World Health Organisation, 2016; Murray & Powell, 2008).
- Young people with sexually abusive behaviours can present with complex issues including family violence, neglect, cognitive and intellectual impairment, and their own sexual victimisation histories (O’Brien, 2010).

Any initiatives to prevent and educate will be required to engage with these complex dynamics as well as other factors to do with risk.

**Intersections of vulnerability**

An added factor for consideration is how gendered inequality intersects with other forms of vulnerability and disadvantage. Some populations are at greater risk of sexual victimisation than others, particularly if multiple disadvantaged social identities overlap. While it is difficult to obtain population level prevalence data, smaller community-based studies both in Australia and internationally suggest that following groups experience higher rates of sexual assault and sexual abuse:

- Women and men with a disability;
- Homeless women;
- Young women;
- Women and men who identify as GLBTIQ; and
- Aboriginal and Torres Strait Islander women and children.

These groups are also more likely to experience revictimisation or multiple forms of victimisation over the lifecourse (Murray & Powell, 2008; Stathopoulos, 2014). However, this should not be taken to mean that there is something about particular populations themselves that makes them more likely to experience sexual assault abuse. A focus on individual or group risk factors cannot account for “how perpetrators may target vulnerable people who have previously been victimised, how community and organisational attitudes and norms may support sexual revictimisation, and how broader social norms create vulnerability for certain groups” (Stathopoulos, 2014, p. 1).
These broader contextual factors should inform prevention strategies as they have implications for how policy, practice, and systems responses can ensure that they do not (re)create circumstances of risk and vulnerability that perpetrators exploit.

**Co-ordinated specialist and non-specialist responses**

As noted at the outset, the dynamics and circumstances in which sexual victimisation occurs are complex – embedded in often intimate relationships, facilitated by the exploitation of trust, largely hidden from and misunderstood by the general public, and until recently viewed as crimes that were easy to allege and difficult to deny. This complexity means that agencies and systems with central responsibility for designing and implementing prevention strategies, as well as responding to victims, perpetrators, or both need to have specialist knowledge of:

- how sexual assault and child sexual abuse occur;
- the tactics and strategies of perpetrators;
- the situational components that contribute to risk (e.g., organisational environments/cultures); and
- the trauma response to sexual victimisation and the needs of victim/survivors.

In addition to sexual assault services, which have provided specialist therapeutic responses to victims of sexual assault and child sexual abuse, there has been a growing trend for specialist responses in the following areas:

- criminal investigations and the police response;
- prosecution;
- adjudication of cases (e.g., specialist courts for child sexual abuse and sexual assault).

At the same time, there has also been a trend for non-sexual assault specialist services and systems to:

- improve their knowledge of child sexual abuse and sexual assault and sensitivity to the possibility that many clients and patients will have trauma histories; and
- develop links and referrals to specialist and other services.

As such, a key area of development has been the establishment of co-ordinated and interagency responses to sexual assault and sexual abuse that may take the form of co-located services; care co-ordination and case co-ordination. The available evaluation research indicates better outcomes for victim/survivors when services (e.g., sexual assault service, police, crisis support) are properly co-ordinated (Powell & Cauchi, 2013; Robinson & Hudson 2008; 2011)) there are also challenges when different disciplines, expertise, traditions and organisational imperatives attempt to work together to be “victim-centred”. Nevertheless, research with adult victim/survivors themselves is clear in identifying what their needs are:

- safety;
- empathy, validation and non-judgement;
- being heard/feeling listened to;
- empowered choice and decision-making;
- flexibility in accessing services;
- responsivity to diversity, life circumstances;
- practical, material forms of support and assistance;
- having a community of peers to connect with (Clark, 2010; Quadara et al. 2014).

**Significance of the fundamental principles**

We see the three fundamental principles as interrelated, and underpinning specific initiatives for a statewide strategy both in shaping high-level programmatic priorities, as well as enabling a shared understanding across key stakeholders, agencies and portfolios about best practices in preventing and
responding to sexual assault. The diagram overleaf provides a visual representation of how these intersect.
Integration of underlying principles

- Develop an evidence-based understanding of the risk and protective factors for the diverse forms of sexual victimisation
- Synthesise to identify the most common and identify the underlying determinants
- Develop logic model that links long term change goals, drivers of change, initiatives to target these and appropriate indicators for short, medium and long term measurement
- Engage relevant policy actors, sectors and stakeholders to ensure interagency commitment

- Use specialist expertise to design systems responses
- Integrate non-specialist and non-therapeutic services into specialist responses
- Draw on existing, broader evidence base about interagency, co-ordinated, wrap-around and co-location service models to design service models
- Innovate funding models, service agreements, workforce training and planning to support this work

- Integrate perspectives on how different dimensions of inequality and disadvantage amplifies risk factors into overall strategy
- Tailor initiatives, programs and interventions to specific communities and populations
- Assess how social and systems responses create or amplify risk

Public health approach to prevention

Specialist, co-ordinated and flexible systems and service responses

Gendered, intersectional view of inequality and risk

Build workforce capacity and systems infrastructure to support initiatives

Adapt, refine and scale up

Use research evidence to inform initiatives

Monitor and evaluate

Tailor for specific communities and settings
SECTION B: RAPID EVIDENCE ASSESSMENT

This rapid evidence review is structured along the lines of the following domains and organised around two issues—child sexual abuse and adult sexual assault:

- prevention and education;
- crisis and long-term support of victims;
- policing and legislative responses; and
- training and capacity building of services.

In this section we outline the research in relation to “best practice” and “what works”, which entails research and practice knowledge from Australia and internationally; namely the United States, United Kingdom, Canada and New Zealand. The findings are presented as summaries as well as tables for ease of reference.

Limitations

The main limitation of this rapid evidence review is the time frame within which the evidence was collected and reported. The specific, narrow focus of the search also introduces limitations to this review. Limitations of the evidence itself include points such as:

- sexual violence of both adults and children is relatively under-studied;
- sexual violence within Indigenous and culturally and linguistically diverse populations is very under-studied;
- there is no clear definition of either sexual assault or child sexual abuse in the research literature;
- results from Australia are limited;
- evaluations of programs are often not undertaken beyond a 6-month period after the program’s completion;
- programs either for training, support or evaluation after often undertaken inhouse, or not undertaken at all; and
- best practice is an undefined term in the majority of the literature.

Defining “best practice”

Currently there is no consensus about “what works” or what constitutes “best practice” in sexual violence and child sexual abuse prevention or response. What the research literature and other evidence presents as successful in preventing or responding to adult, youth and child victimisation and perpetration of sexual violence will be covered in the following sections. In this section, the focus is on defining the widely used term “best practice”.

There is no uniform definition for “best practice” in the child and adult sexual assault response field. The term is contested, and in reviewing the literature there was often no service, policy or research definition of the term. The term “best practice” has been used in a number of Australian sexual assault policy and guideline publications (see, for instance, National Association of Services Against Sexual Violence [NASASV], 2015; Government of South Australia, 2013; Quixley, 2010). The lack of a clear definition for “best practice” is not just an issue for sexual assault service providers but also for those working in or with the domestic and family violence services (Breckenridge & Hamer, 2014). As this section will discuss, the term “best practice” is complex, although there are some basic concepts that may provide guidance for developing an appropriate definition.

The term “best practice” has its recent origins in the Cochrane Collaboration from the early 1990s in the United Kingdom, which often inform research and policy due to the systematic reviews that are undertaken to search for and find “gold standard” evidence (Breckenridge & Hamer, 2014). While the work undertaken by experts creating the Cochrane Reviews is extensive and systematic, evidence that is quantitative, clinical or methodologically similar to health and medical research is promoted over
qualitative, practitioner experience or evidence informed by the lived experiences of individuals. As Webb (2001) noted, the idea that applying outcomes from rigorous, scientific (not social-science) method-based research projects is highly appealing to contemporary cultures. Practices that are based on research evidence can be presented as a cure to costly and difficult social issues. However, in areas of human services these research practices have often not been appropriately critiqued and a rigid application of them to services may actually prevent solving the issues that the evidence is purported to have solved theoretically (Webb, 2001). Researchers have also indicated that they dislike the term “best practice” because it implies that the application of evidence-based research will lead to the problems being solved without evaluation, individualisation or change (Bowen & Zwi, 2005; Breckenridge & Hamer, 2014). Services dealing with sexual assault and child sexual abuse may also be operating under a variety of political, philosophical or methodologically diverse systems, which can lead to a disagreement about what constitutes “best practice” (Breckenridge & Hamer, 2014).

The NASASV (2015) guidelines and standards acknowledge that while their guidelines are “based on and are referenced to worldwide best practice and … developed in consultation with sexual assault services in all Australian States and Territories” (p. 4), practice that is informed purely by research evidence is not necessarily guaranteed to work because “it cannot be assumed that an intervention clinically proven to be successful with one client group experiencing a certain set of symptoms will achieve the same results with a different client group” (p. 52). NASASV argued that effectiveness of programs and practices should come from client-based review and feedback, research literature, reflective practice and “outcome evaluations methods that are client focused” (p. 52). The focus on not only research evidence but also client review and feedback and evaluations of programs has been highlighted as important to creating best practice models in sexual assault and other violence against women services (Carmody, Evans, Krogh, Flood, Heenan & Ovenden, 2009).

General criteria for what would be considered best practice in rape prevention and treatment support for female victims of rape was suggested by the European Union’s Directorate-General for Internal Policies (Walby et al., 2013). Criteria included: being victim-survivor centred; being gender expert and gender sensitive; including the participation of survivors; having trained personnel; having “skilled specialised centres that act as beacons to good practice in the mainstream”; having monitoring and evaluation built into the services and programs in order to continuously update practice; inter-agency collaboration; and being part of a broader package of policies to combat violence against women (Walby et al., 2013, p. 34). Practices that are “innovative, proven to have made a difference, and models for development elsewhere” can be classed as being part of the best practice, whereas others should be classified as “promising practices” (Walby et al., 2013, p. 34). Sexual assault services that are informed by similar criteria have been referred to as “practice-informed” (Plath, 2006), or “evidence-influenced” (Bowen & Zwi, 2005) rather than as “best practice”.

Research has also highlighted that while international evidence-informed or influenced models for public health services may be promising, they may be difficult to translate to Australia where many funding guidelines are rigid and heavily regulate what kind of models may be used by services and who may deliver them (Breckenridge & Hamer, 2014). This could have implications for using practice-informed evidence to guide services without research input as “various incarnations [of services] may well be driven by particular ideological positions or economic agendas that are obscured by claims of objectivity” (Breckenridge & Hamer, 2014, p. 3). This is arguably an issue in Australia with regards to child sexual abuse education prevention programs that are labelled “protective behaviours” or are based upon protective behaviours education. Research indicates that these have mixed results at best and that Australian programs have not been rigorously evaluated; however, these are the programs that continue to receive ongoing funding from state and territory governments based on internal, practice-informed criteria (Quadara et al., 2015).

The following section begins the presentation of the findings of the Rapid Evidence Assessment. For some of the domains under investigation, child sexual abuse and adult sexual assault will necessarily overlap—such as crisis and long-term services.
Domain 1: Prevention and education—child sexual abuse

Currently in Australia there is no whole-of-system or whole-of-government response to child sexual abuse, although there are a number of major policy frameworks that address sexual abuse such as the National Plan to Reduce Violence against Women and their Children and the National Framework for Protecting Australia’s Children 2009-2020.

Primary prevention of child sexual abuse and protective behaviours education

Current CSA prevention programs in Australia focus on preventing victimisation. Child sexual abuse prevention in Australia is primarily envisaged as part of “protective behaviours” education. Protective behaviours education is school-based programs aimed at equipping children with “the knowledge and skills to act in ways that reduce the likelihood of abuse occurring and helping them report the abuse and seek help if abuse occurs” (Hawkins, 2013). As researchers note, an issue with victimisation prevention programs is that these programs may give a false sense of security to parents and communities (Finkelhor, 2009), can place responsibility on the child to stop the abuse by disclosing, and cannot be classified as entirely preventative as the programs focus on children disclosing abuse, which means that the child has to have been a victim of CSA (Barron & Topping, 2009; Walsh, Zwi, Woolfenden, & Shlonsky, 2015). Research results also indicate that after 12 months with most participants there was little improvement in “safe” or “protective” responses; for example, children asserting their rights or finding an adult to tell about their feelings of unsafety (Barron & Topping, 2009; Hawkins, 2013). Due to these research results, internationally there has been movement away from victimisation prevention to perpetration prevention. There are various primary prevention programs available internationally that are concerned with CSA perpetration, which will be detailed later.

Current CSA prevention programs in Australia do not take into consideration that a large minority of CSA is either sibling sexual abuse or peer-on-peer sexual abuse (Higgins, 2013; Stathopoulos, 2012). Table 1 lists a selection of the current CSA prevention programs available in Australia.1

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### Table 1: Selection of CSA programs in Australia

<table>
<thead>
<tr>
<th>Name of program</th>
<th>State availability</th>
<th>Type of intervention</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ditto’s Keep Safe Adventure</td>
<td>QLD, NSW, Vic., Tas.</td>
<td>One-off performance and a take-home book for the child. Protective behaviours based.</td>
<td>Fair. External review by NSW Centre for Education Statistics and Evaluation found: broadly aligned to curriculum, does not consider CALD backgrounds, no consideration for children’s development, does not teach new child protection messages but can be fun for children, does not use anatomically correct terms but series of words that are specific to program, differentiates between types of touches (e.g. good/bad) that children may not be mature enough to differentiate.</td>
</tr>
<tr>
<td>All Children Being Safe (NAPCAN)</td>
<td>NSW</td>
<td>Multi-lesson program for 4–7 year olds to feel confident and safe in their communities.</td>
<td>Unknown</td>
</tr>
<tr>
<td>Supporting Hands: Introduction to Child Sexual Abuse</td>
<td>QLD</td>
<td>2-hour seminar for adults in the community who have an interest in finding out about CSA. Provides general info, risk factors, addresses myths.</td>
<td>Unknown</td>
</tr>
<tr>
<td>Feeling Safe Together, SECASA</td>
<td>Vic.</td>
<td>2–3 hours, delivered to up to 25 students at a time. Run for boys and girls Prep. to Grade 6. Focus is on feeling safe vs feeling unsafe, teaching children that they have rights and can control their own bodies.</td>
<td>Unknown</td>
</tr>
<tr>
<td>The Safe Program</td>
<td>National</td>
<td>For 7–12 year old deaf students to learn about keeping safe, feeling safe and being in control of their bodies.</td>
<td>Unknown</td>
</tr>
<tr>
<td>Child Safe Organisations</td>
<td>National</td>
<td>State and territory governments are introducing compulsory minimum standards that apply to organisations providing services for children to help protect children from abuse.</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Children receive varied education about sexual abuse due to there being no consistent policies regarding what qualifies as CSA prevention education at either state or federal level; no policies on student assessment following education, who should teach the children about CSA prevention, or if parents should know that their children are being educated about CSA (Quadara et al., 2015). Table 2 outlines the policies on CSA prevention education for each state and territory.

Table 2: State and territory CSA education policies

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>• Specifically addresses the role of teachers in sexual abuse prevention</td>
</tr>
<tr>
<td></td>
<td>• Commitment in curriculum to provide sexual abuse prevention education</td>
</tr>
<tr>
<td></td>
<td>• Sexual abuse education must take place in Health and Physical Education classes</td>
</tr>
<tr>
<td></td>
<td>• Offers guidelines to teachers for use of external providers for CSA education</td>
</tr>
<tr>
<td></td>
<td>• Stipulates that teachers must receive training in child sexual abuse prevention before giving classes</td>
</tr>
<tr>
<td></td>
<td>• Students can be assessed on what they’ve learned</td>
</tr>
<tr>
<td>New South Wales</td>
<td>• Weak commitment in school curriculum to sexual abuse prevention—up to school whether they want to provide it</td>
</tr>
<tr>
<td></td>
<td>• Sexual abuse education taught within the Personal Development curriculum</td>
</tr>
<tr>
<td></td>
<td>• Sexual abuse education must take place in Personal Development classes</td>
</tr>
<tr>
<td></td>
<td>• Schools must seek parental approval to deliver classes to students</td>
</tr>
<tr>
<td></td>
<td>• Information for parents about CSA education is limited to cybersafety websites in English</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>• Doesn’t explicitly mention child sexual abuse prevention as compulsory study</td>
</tr>
<tr>
<td>Queensland</td>
<td>• Doesn’t explicitly mention child sexual abuse prevention as compulsory study</td>
</tr>
<tr>
<td></td>
<td>• Students can be assessed on what they’ve learned</td>
</tr>
<tr>
<td>South Australia</td>
<td>• Specifically addresses the role of teachers in sexual abuse prevention</td>
</tr>
<tr>
<td></td>
<td>• Commitment in curriculum to provide sexual abuse prevention education</td>
</tr>
<tr>
<td></td>
<td>• Stipulates that teachers must receive training in child sexual abuse prevention before giving classes</td>
</tr>
<tr>
<td></td>
<td>• Students can be assessed on what they’ve learned</td>
</tr>
<tr>
<td></td>
<td>• Parents can opt out of CSA education but if they do then teachers need to find out why</td>
</tr>
<tr>
<td></td>
<td>• Information for parents about CSA education is limited to cybersafety websites in English</td>
</tr>
<tr>
<td>Tasmania</td>
<td>• Sexual abuse prevention education part of Physical Education and Health and Wellbeing curriculum</td>
</tr>
<tr>
<td></td>
<td>• Doesn’t explicitly mention child sexual abuse prevention as compulsory study</td>
</tr>
<tr>
<td>Victoria</td>
<td>• Weak commitment to providing sexual abuse prevention education—up to school to decide to provide it</td>
</tr>
<tr>
<td></td>
<td>• Doesn’t explicitly mention child sexual abuse prevention as compulsory study</td>
</tr>
<tr>
<td></td>
<td>• Offers guidelines to teachers for use of external providers for CSA education</td>
</tr>
<tr>
<td></td>
<td>• Students must be assessed on what they’ve learned</td>
</tr>
<tr>
<td></td>
<td>• Parents can opt out of CSA education for their children</td>
</tr>
<tr>
<td></td>
<td>• Information for parents about CSA education is limited to cybersafety websites in English</td>
</tr>
</tbody>
</table>
Western Australia

- Specifically addresses the role of teachers in sexual abuse prevention
- Commitment in curriculum to provide sexual abuse prevention education
- Sexual abuse education must take place in Health and Physical Education classes


There is limited data available about the evaluation of Australian school-based protective behaviours education programs (there is only one Australian Research Council-funded project assessing both primary and secondary school prevention programs but it is still an ongoing research project). International research about the effectiveness of sexual abuse prevention programs and respectful relationships programs (aimed at 12–25 year olds to teach them respect in platonic and romantic relationships and prevent peer sexual assault) has found mixed evidence for their effectiveness, with one research review finding that there was no evidence at all for the effect of interventions on the outcomes reported (Fellmeth, Heffernan, Nurse, Habibula, & Sethi, 2013).

**Sibling sexual abuse and peer-to-peer sexual abuse**

As mentioned previously, sibling sexual abuse and peer-on-peer CSA constitute a large minority of CSA offences (Stathopoulos, 2012). Research about both is limited and often fragmented due to issues of definition (especially with regards to peer-on-peer CSA often not being considered a form of CSA but a form of relationship sexual assault) and a lack of research (especially of sibling sexual abuse). These forms of CSA do not feature in prevention education programs.

The literature suggests that in cases of sibling sexual abuse, incorporating the entire family into therapy sessions can have a positive impact on recovery (Welfare, 2010). Caffaro and Conn-Caffaro (2005) suggested a multi-disciplinary approach that integrates assessments and treatment responses constitutes best practice in dealing with the complex and challenging needs of each individual family member.

For the abused sibling, therapy can be an important avenue to recovery and can avert traumatic manifestations such as drug and alcohol abuse, mental health issues and social isolation. An important consideration for older abused siblings is being compelled to spend time with abusive siblings due to family obligations, particularly as parents become older (Monahan, 2010).

For the sibling who has displayed problematic sexual behaviours towards sibling/s it is important to consider the risk of “mental pathologies, a history of behavioural disorders and/or a history of being abused” (Stathopoulos, 2012). O’Brien (2010) suggested that it is vital for the child displaying problematic sexual behaviours to receive therapy in order to stop the behaviour and the possibility that the behaviours may become more violent.

Further research is required into both forms of CSA, and research into the prevention of sibling sexual abuse is highly required.

**Children and young people who display problematic sexual behaviours**

Treatment for children with problem sexual behaviours and adolescents with sexually abusive behaviours is available in Victoria through specialist practice. Children (both victims and those with sexually problematic and abusive behaviours) and their families are catered for as part of this program. The focus is on uncovering the causes of the child or young person’s sexually problematic and abusive behaviours and creating a treatment and intervention plan that ensures safety for all children as well as reducing the inappropriate behaviours (Evertsz & Miller, 2012).

Various outreach services are also available for Aboriginal communities in the Northern Territory where children and young people are displaying sexually abusive or problematic sexual behaviours, or where children, their families and communities are suffering trauma after abuse, neglect or sexual assault (O’Brien, 2010). Other programs for young people who have displayed sexually abusive behaviours, or have been convicted of offences over the age of 16 years, are available throughout Australia but are often underfunded, available only to a limited number of youth per annum and
tertiary prevention measures (i.e., concerned with preventing recidivism rather than primary prevention) (O’Brien, 2010); Victoria and Queensland appear to be the only states with funded specialist services for responding to youth justice clients (O’Brien, 2010). As noted by Evertsz and Miller (2012), a large number of children and young people with sexually abusive and problematic sexual behaviours are themselves victims of CSA and therefore treatment of youth who are suspected of CSA perpetration needs to consider how to ensure the safety and healing of the young person who is also abusive with their behaviours.

**Best practice for problematic sexual behaviours**

It has been widely recognised that responding to problematic sexual behaviours (PSB) in children and youth requires therapeutic services that focus on enacting behavioural change in the young person and diverts them away from the juvenile justice system. Similar to CSA perpetrated by adults, and sexual assault (SXA) more broadly, numbers regarding PSB are unknown, although it is estimated that a large number of intra-familial CSA is perpetrated by siblings (Stathopoulos, 2012). Australian research estimates that sexual abuse by young people accounts for between 40 and 90% of sexual offending against children (O’Brien, 2010). The same obstacles to reporting CSA and SXA victimisation are an issue for reporting young people’s risk of committing sexual abuse—shame, misinformation, denial and confusion can lead to young people with PSB not receiving the treatment they require.

In Victoria, therapeutic treatment services are available to young people with PSB, their families, carers, schools or community services. The aims of the treatment are to:

- prevent further occurrence of the behaviour;
- engage the young person to address the impact of their behaviour; and
- improve the wellbeing of affected family members (Department of Human Services [DHS], 2012).

South Australia’s policy of responding to children and youth who display PSB is underpinned by guidelines of best practice from South Australian, Australian and international law and social service guidance (Department for Education and Child Development [DECD], 2013). These include the United Nations Conventions on the Rights of Children, various SA laws including the *Children’s Protection Act 1933* and *Young Offenders Act 1993*, the National Safe Schools Framework, Information Sharing Guidelines (SA guidelines for sharing information across government and non-government services to ensure the protection of children), SA guidelines for professional boundaries for teachers and other school staff, individual school and child care centre policies, and the Keeping Safe Child Protection Curriculum that includes teaching children about respectful relationships and recognising and reporting sexual abuse (DECD, 2013). It is recognised that responding to PSB is a specialised area within service delivery and requires specialist training for practitioners and clinicians (DECD, 2013; Evertsz & Miller, 2012; SASS, 2014).

Best practice for responding to PSB has resulted in the creation of policies in Victoria and South Australia that include:

- establishing clear guidelines of immediate responses from adults if PSB are exhibited onsite at a school, day-care centre or other site with young people under the care of adults;
- if harm and PSB occurred off-site then staff must notify authorities as soon as they learn of the abuse;
- ensuring that information is gathered in a non-interrogative way and through an ecological perspective that considers the manner in which there may be contributing factors to the display of PSB;
- ensuring that authorities are contacted first before parents and guardians of the child/youth with PSB are;
• ensuring that individuals are mindful of domestic and family violence possibilities as well as authorities checking for criminal records of adults who are parents, carers or guardians of the child with the PSB;
• ensuring that professional counselling services that are able to provide help and support to children and youth with PSB and their families are available
• Ensuring that schools and other sites are consulted and liaised with in the creation and implementation of behaviour support plans or if a child or young person must be moved, that plans can be adhered to and implemented in the new site;
• building relationships with the family as well as other important services within the child/young person’s life (e.g., GP) in gathering information that will help support the child/young person;
• ensuring privacy of young people with PSB is upheld;
• site reviews are undertaken when an institution is the place where the PSB were exhibited;
• consideration of the child’s mental and emotional health are considered alongside the parents’ ability to parent and stress levels within the family are monitored; and undertaking a risk assessment that is current and focused on the immediate risks (DECD, 2013; Evertsz & Miller, 2012).

Victoria’s response to PSB in children and youth stresses that:
• safety is a prime consideration for both the subject child and those around them;
• their behaviour is linked to multiple stressors— both external and internal to the child;
• in children under 10, persistent sexualised behaviours are developmentally abnormal and are likely to indicate that harm has occurred to the child;
• the younger the child, the more likely this is;
• once in a repeating pattern, the behaviours may be habitual and the child can no longer control them—treatment should be sought from the Problem Sexual Behaviours and Sexually Abusive Behaviour Treatment Service agency;
• family and/or caregiver involvement is paramount and needs to be effective;
• multiple factors need to be addressed, perhaps via different service providers, and service providers have a strong role in facilitating these services; and
• coordination and a well-functioning care team is critical to successful outcomes (Evertsz & Miller, 2012).

Children and young people, technology and cybersafety

Policies regarding children and young people’s safe use of technology and their cybersafety are available in all states and territories of Australia. However, none are explicitly about child sexual abuse or sexual assault prevention, but rather are part of a national approach to address bullying, violence, harassment, child abuse and neglect (Office of the Children’s eSafety Commissioner, n.d.). Each state and territory’s education department is responsible for developing policies governing the appropriate use of Internet, mobile phones and other digital technologies within schools; independent schools in each district have also developed policies about this issue (Office of the Children’s eSafety Commissioner, n.d).

In Victoria, the Department of Education and Training developed the program “Bully Stoppers” to respond to bullying behaviour in both primary and secondary schools. NSW’s Department of Education and Communities have developed parent information sheets and anti-bullying programs for schools; however, these are not specifically sexual assault or abuse related. In Queensland, a portal is hosted by the Department of Education, Training and Employment in conjunction with the federal Department of Communications and the Arts but this is a mostly static site with links to the ThinkUKnow site (an Australian Government initiative to teach youth about cybersafety) and the

portals where social media content can be reported with the relevant social media site. Other states and territories have made their policies available online with parental pamphlets but do not host a separate site for parents or youth to access. Currently it is difficult to discern what information is being made available to children and young people about the sharing of sexually explicit images (consensually and non-consensually).

Researchers have noted that adults should not assume that all sharing of images is non-consensual or that girls and boys are being coerced into sharing sexually explicit material, as the introduction of smart phones and other digital devices and apps is changing young people’s relationships (Lee, Crofts, McGovern, & Milivojevic, 2015). It is recognised, however, that digital devices are leading to the technologically facilitated sexual violence of young women (Henry & Powell, 2015a, 2015b; Powell & Henry, 2014). As other researchers note, adults also regularly engage in consensual sexting and therefore sexting should be viewed as increasingly part of normative human sexual behaviour rather than as something either for teens or something that is only exploitative (Willard, 2010). Legal and policy responses to young people’s sexting and engagement in the sharing of sexually explicit material is not well developed in Australia and more work is required with young people to discover how they are engaging in this activity and what their concerns are.

**Primary prevention of child sexual abuse aimed at (potential) perpetrators**

Table 3 outlines the major international initiatives to prevent child sexual abuse perpetration or recidivism.

**Table 3: International perpetration prevention initiatives**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elmira Project (USA)</td>
<td>Aimed at low socio-economic mothers and infants (families marked as being “at risk” due to other extraneous factors established by child protection services) in order to have a positive effect on maternal relationships with children and lower chances of CSA offending in the long term.</td>
</tr>
<tr>
<td>Project Protection Dunkelfeld (Germany)</td>
<td>Aimed at primary prevention of offending amongst paedophiles and hebephiles. Established in 2002. Receives support from victim support organisations, media relations and campaign companies. Advertisements for PPD are widely presented on television, radio and billboards. Aimed at undetected paedophiles and hebephiles who have not offended against any children. Any offending results in instant notification to authorities. If no offending takes place their participation remains anonymous. No major evaluations yet but looks promising.</td>
</tr>
<tr>
<td>Stop it Now! UK &amp; Ireland (also available in USA)</td>
<td>Hotline for individuals who are worried about their thoughts or behaviour, non-offending partners and health service personnel who have questions or concerns. UK justice system is involved—individuals cautioned for their behaviour or on bail awaiting trial can receive help from organisation. Young offender programs. 2/5 of callers not offenders but concerned about their thoughts or use of child pornography. US program is only telephone counselling, focus primarily on victims. No individual evaluation but considered very effective. A version of it has been introduced to Australia, at Phoenix House in Bundaberg, Queensland. Details about it via websites are limited. It is unknown if it is effective. It does not appear to have political or metropolitan sexual assault service backing. It appears to be like the US version not the UK/Irish one.</td>
</tr>
</tbody>
</table>

Source: Adapted from Quadara et al. (2015).

These international programs, aimed at both primary prevention of child sexual abuse and prevention of recidivism, move prevention efforts to adults to prevent them sexually abusing children. It is not to suggest that these are the only programs to prevent child sexual abuse available in these countries.

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Domain 1: Prevention and education—adult sexual assault

Prevention

Research argues that effective primary prevention of sexual violence requires targeting the complex, systematic causes of this crime (Wall, 2013). As Wall (2013) states “primary prevention strategies can be targeted at aspects of causation, or aim to effect change in individual communities, but these are incremental steps toward broad-scale social change to remove the conditions that lead to sexual assault (2). The National Association of Services Against Sexual Violence (NASASV) has developed guidelines for developing primary prevention programs. The majority of sexual assault prevention training and programs come from sexual assault service providers. Specific sexual assault primary prevention programs include:

- Sex & Ethics (Australia wide): for men and women 16–25 years old.
- The Line Campaign (Australia wide): young people aged 12–20 years.
- No to Violence (Vic.): for men; men’s behaviour change programs where men have been referred for their offending (preventing recidivism); sexual assault and violence against women;
- Building Respectful Relationships—Stepping out Against Gender Violence (Vic.): program targeting bystanders and other youth to intervene;
- Respectful Relationships (Vic.): aimed at secondary school communities to implement a whole-of-school approach to prevent sexual violence and violence against women;
- Y Respect Gender (Vic.): prevention of sexual assault and violence against women within organisations;
- Take a Stand (Vic.): organisational cultural change to prevent sexual assault and violence against women;
- Love Bites (NSW): secondary school communities whole-of-school approach to prevent sexual assault;
- Sexual Assault Prevention Program for Secondary Schools (SAPPSS) (ACT/Vic.): similar to Respectful Relationships programs; also available for students with disabilities;
- Sexual Assault Prevention Education (SAPE) (NT): aimed at students, GPs, educators, nurses, volunteers and police; range of education programs to reduce sexual assault and recognise it; and.
- Respect, Protect, Connect (Vic.): run by South Eastern Centre Against Sexual Assault (SECASA) for secondary students; also available in Tasmania.

Evaluations of the Sex & Ethics program have indicated that the program has been successful in targeting young people and their understanding about their own as well as their partner’s sexual needs. Findings also indicate that the program is successful in developing ethical responsibility in both male and female program participants and bystander skill acquisition and use even 4—6 months after participation in the program (Carmody, Ovenden, & Hoffmann, 2011).

OurWatch has recently released their evaluation of Respectful Relationships education based on evidence from Australia and internationally and found that while the evidence suggests that Respectful Relationships education is effective as a form of primary prevention (preventing gender-based violence against women, including sexual assault), more research is required to find the most

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4 Information about these services is based on what is easily accessible via Internet searches and did not require contacting the services for more information.
effective models to introduce to Australian schools (Gleeson, Kearney, Leung, & Brislane, 2015). Initial assessment of The Line campaign has found that there were positive shifts in youth understanding about the acceptability of sharing intimate or nude photos, as well as slight decreases in the belief that intoxication or what a girl/woman wears creates responsibility for unwanted sex (Gleeson et al., 2015).

Other education programs are available in primary and secondary schools; however, these tend to have a broader focus of violence against women prevention rather than specifically sexual assault or sexual violence prevention. Respectful relationships education that is focused on the prevention of violence against women, and other forms of interpersonal violence between individuals, has been introduced in selected schools with success. As Flood, Fergus and Heenan (2009) noted, these programs are successful in the long term when there is:

a) a whole-school approach (including all staff and students and across all school levels);

b) a program framework and logic;

c) effective curriculum delivery;

d) relevant, inclusive, culturally sensitive practice; and

e) impact evaluation.

For adults, sexual assault prevention education has also been included in primary prevention of violence against women programs, and programs aimed at preventing the harassment of women in workplaces. VicHealth has created a framework for preventing violence against women (2007–2009), which includes societal, community, organisational and individual-level responses for preventing violence. The Respect, Responsibility and Equality Program (2007–2015) (also developed by VicHealth) contained four phases of engagement with the community through various smaller projects to build safer and more respectful environments for women (Flood, 2013). VicHealth also funded and supported the Creating Healthy Workplaces Program (2012–2015) to trial strategies that would promote equality in the workplace, increase women’s representation and leadership in the workplace and create respectful working conditions. Whole of society and community-led programs have demonstrated greater efficacy than short-term programs that are presented by “outsiders” to a community (e.g., not locally based educators who understand the community they are presenting to), and are not specific and individualised for the community (e.g., programs developed for English as first-language individuals being presented to CALD community members) (Allimant & Ostapiej-Piatkowski, 2011).

**International programs**

There are several different attempts being made internationally to prevent sexual abuse and violence. Regarding both adult sexual assault and child sexual abuse prevention programs, the focus of governments, research organisations and service providers is increasingly on preventing perpetration. Due to this, increased funding and more sexual assault prevention programs are aimed at youth and children to develop healthy bonds and relationships with peers. These programs, such as the Respectful Relationships education, are also available in Australia and are outlined above.

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5 It is worth mentioning the Safe Dates program, which fell just outside our review inclusion dates. Safe Dates was an adolescent dating sexual assault prevention program run in US schools, and evaluations and follow ups occurred up to 4 years after the program ran. Results indicated that the program showed great promise for preventing violence amongst dating teens. There was less certainty in relation to “booster” sessions provided to randomly selected treatment participants (Foshee, Bauman, Ennett, Linder, Benefield, & Suchindran, 2004).

Education

Sexual assault service providers worldwide are often the providers of prevention education programs within schools and the community. Programs that have been identified as “best practice” (Walby et al., 2013) include:

- Sexual Assault Crisis Teams (SACT) (USA, Vermont): primarily offering victim/survivors support but also education to community groups. No further information offered on website.
- National Sexual Violence Resource Center (SARC) (USA, nationwide): Rape Prevention and Education program, Engaging Bystanders in Sexual Violence Prevention programs, Sexual Violence and the Workplace program are all run on demand.
- Southampton Talking About Relationships (STAR) (UK): similar to respectful relationships education in Australia to prevent rape by empowering young people. Evaluation finds it very successful.
- #talkaboutit: talking about consent and coercion (Sweden): community, grassroots-level prevention program creating public debates about rape and coercion; talking about events that men and women may not consider rape but actually are.

Walby et al. (2013) identified these as best practice programs due to their innovative nature, their reduction of silence around sexual violence in the community acting as a preventative measure, local support, engagement with bystanders and for taking the prevention training into the workplace.

Domain 2: Crisis and long-term support services for victim/survivors of child sexual abuse and adult sexual assault

For crisis and long-term support services the literature regarding “best practice” and “what works” will be presented together for both child sexual abuse and adult sexual assault. This is partly because there are some overlaps in therapeutic approaches and service providers.

Since the 1970s there has been focus on providing adult and child victim/survivors of sexual assault support that is specific to the physical, emotional and sexual trauma experienced (Jones, 2015). This includes not only immediate crisis counselling and appropriate forensic examination but ongoing support. Victim/survivors of sexual violence can experience a variety of issues in the short and long term:

Short-term:
- physical injuries;
- sexually transmitted infections;
- anxiety;
- fear;
- flashbacks;
- nightmares; and
- shame

Long-term:
- post-traumatic stress disorder;
- ongoing physical problems;
- depression;
- sexual problems;
- relationship breakdowns;
- drug and alcohol abuse; and
However, the needs of survivors in crisis and long-term care can differ based on whether they are male or female (Price-Robertson, 2012), abused as children (Denov, 2004), abused as adults (Burke Drauker, 1999), and whether they had solid support networks around them at time of their first disclosure (Quadara et al., 2015). This section considers what services are currently available around Australia and what needs victim/survivors have that may not be currently met as well by services in Australia.

### Sexual assault specific services

Sexual assault centres and services in Australia, and internationally, generally provide multidisciplinary care for men and women who have been victims of sexual crimes. Services include support, counselling, advocacy services, training and education. Non-government services are often specific about who they are willing to offer services to (e.g., offering support only to male, only to female, only to adult, or only to child clients) and due to funding there may be limits on whether victims can access long-term support. Nationally, crisis and long-term support for victim/survivors of either adult or child sexual abuse can be received from 1800-Respect, the national sexual assault, domestic family violence counselling service, or from Kids Helpline. 1800-Respect offers both telephone and online counselling, as does Kids Helpline. Both services are available 24 hours per day/7 days per week.

On a state and territory level there are sexual assault services that offer crisis and long-term support for victim/survivors and non-offending family members. Table 4 gives details of the main contact services for each state.7

#### Table 4: Contact services

| Australian Capital Territory | • Canberra Rape Crisis Centre  
|                            | • The Nguru Program: a culturally appropriate counselling service for members of the Aboriginal and Torres Strait Islander community  
|                            | • Service Assisting Male Survivors of Sexual Assault (SAMSSA) |
| New South Wales            | • Rape and Domestic Violence Services Australia: 24 hours per day/7 days per week telephone and online counselling service  
|                            | • New South Wales Health Sexual Assault Services: 58 services around NSW that offer crisis and long-term support  
|                            | • Adult Survivors of Child Abuse (ASCA): Focus primarily on adults CSA survivors. Counselling, advocacy and training in CSA needs of adult survivors |
| Northern Territory         | • Ruby Gaea (Darwin Centre Against Rape): Crisis and long-term counselling for women and children  
|                            | • Sexual Assault Referral Centre: Crisis support and other counselling and support needs (24 hours per day/7 days per week)  
|                            | • Sexual Assault Referral Centre and Counsellor (Alice Springs): Crisis support and other counselling and support needs (24 hours per day/7 days per week)  
|                            | • Sexual Assault Referral Centre (Katherine)  
|                            | • Sexual Assault Counsellor (Katherine)  
|                            | • Sexual Assault Referral Centre and Counsellor (Tennant Creek) |
| Queensland                 | • Sexual Assault Helpline  
|                            | • Queensland Sexual Assault Services: 19 local and community sexual assault services that offer crisis and long-term support to victim/survivors. Many have different focuses (e.g. Living Well: Sexual Assault Services for men offers online, telephone and in-person support). All offer counselling and support, some offer advocacy. |

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7 Smaller sexual assault services—those affiliated with hospitals, those that do not have websites, or those under the guidance of an umbrella organisation—are not included here but can be accessed on the 1800-RESPECT website.
Crisis intervention

Crisis intervention is available and accessible for most victim/survivors in urban areas around Australia. Rural and remote community members may be geographically isolated from services that would allow for face-to-face counselling, and therefore are reliant on telephone or online counselling. Research indicates that online counselling is primarily through the medium of email and is of a relatively short-term nature (Chester & Glass, 2006). Other research has found that if clients do not progress through the stages of counselling across multiple online sessions, then their levels of psychological distress may not lessen (Dowling & Rickwood, 2014). Research into online counselling is, however, predominantly concerned with youth and children, using small numbers of research participants, and has not covered online counselling offered by sexual assault services in Australia or around the world. Research into this area is necessary, especially in Australia where populations may rely on online counselling exclusively for their crisis or long-term support needs.

Location of sexual assault specialist support services

Recommendations have been made internationally about access to sexual assault services. In Ireland it was recommended that no individual be more than a 3-hour drive from a centre; in the UK it was recommended that one centre be placed every 80km so no individual had to travel further than 120 minutes to receive care; while elsewhere in the EU it was recommended that one service was required per 400,000 women to ensure ease of access and support (Eogan, McHugh, & Holohan, 2013). The Stern Review (Stern, 2010) noted that a “one size fits all” model is not appropriate, and there will need to be differences at local levels to ensure that victim/survivors feel comfortable seeking out support; however, these services must be integrated with other agencies to ensure that they do not become stand-alone sites but work with other agencies to provide care. Access to services at this level in Australia may be difficult to provide due to the geographic size of states and territories.

The provision of sexual assault specialist support services in rural and remote locations

Wilson and McCormack (2010) highlighted the pros and cons of decentralising sexual assault services in order to provide access to services to individuals living in rural and remote communities. Clients noted that accessing decentralised services can be positive but there are travel costs associated with presenting to rural services as well as issues with finding services in a community that is not the victim/survivors’ own community, and difficulties in attending due to concerns about privacy and times when the individual can remove themselves from their community without suspicion (these may coincide with times when services are closed, e.g., over Christmas or Easter) (Wilson & McCormack, 2010).
It is further noted that there are issues with offering sexual assault services to small communities where the decentralised service only has one or few workers. Also, community education and responding to sexual assault may be difficult due to the community’s inherent preference to deny the sexual assault and potentially support the perpetrator (Rawsthorne, 2003). Services in Victoria do not appear to be as affected by these issues in part due to the size of the state as well as the manner in which sexual assault services are organised. They do also offer online counselling for individuals via chat programs such as MSN and video counselling via Skype (Wilson and McCormack, 2010; Forgan, 2011). Other states’ sexual assault services have also begun using video and online conferencing for victim/survivors who are remotely located (Forgan, 2011; Parkerville Children and Youth Care, 2015).

The provision of online counselling

Female survivors of rape and other sexual assault have reported that they are open to and would welcome the opportunity to receive online counselling whether they are in metropolitan or rural communities (McCreight, 2010).

A review of possibilities for online therapeutic interventions has identified four categories for online interventions (Barak, Klein & Proudfoot, 2009):

- web-based interventions (self-guided therapeutic interventions via an online program and interactive web-based programs);
- online counselling and therapy (audio, visual, text-based and a combination thereof);
- Internet-operated therapeutic software (e.g., virtual reality environments); and
- other online activities (e.g., supplements to face-to-face therapy).

Initial research across a variety of fields indicates that online counselling can be as effective as face-to-face counselling. Even when there are no perceptible benefits of online counselling, there are no threats to the mental health of the individual receiving counselling either (Barak et al., 2009).

The need for flexibility in service delivery has been highlighted in the National Plan to Reduce Violence Against Women and Their Children (COAG, 2011). Issues with sexual assault service provision associated with geographic distance in Australia include problems such as:

- finding individuals to work in remote and regional communities;
- the need for culturally sensitive responses that sometimes cannot be well met if individuals are untrained;
- local communities’ sense of self-reliance and belief that threats to the community come from outside and not within;
- lack of integration with other services such as GPs; and
- lack of opportunity to evaluate if measures introduced by individual services are having the desired effects (Wall & Stathopoulos, 2012).

Therapeutic and non-therapeutic support needs of adult survivors of child sexual abuse

Male and female adult victim/survivors of child sexual abuse have also highlighted a variety of therapeutic and non-therapeutic support needs that they feel currently are not being met either by CSA services or by other health care professionals and service providers in the broader community. Table 5 outlines the common concerns raised by male and female survivors of CSA with regards to therapeutic and non-therapeutic needs.
Table 5: Therapeutic and non-therapeutic needs of adult survivors of child sexual abuse

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic needs</strong></td>
<td><strong>Therapeutic needs</strong></td>
</tr>
<tr>
<td>- Respect and understanding that men can be victims of CSA</td>
<td>- Counselling for partners or carers</td>
</tr>
<tr>
<td>- Respect and understanding that male victims of CSA do not go on to perpetrate abuse themselves</td>
<td>- Feeling empowered by the therapy</td>
</tr>
<tr>
<td>- Sexual assault services that do not view men who approach them as perpetrators of sexual violence</td>
<td>- Therapists with a strong understanding of CSA</td>
</tr>
<tr>
<td>- Recognising CSA over lifespan</td>
<td>- Specialised practitioners to help</td>
</tr>
<tr>
<td>- Anger management needs</td>
<td>- Body-oriented therapies (e.g., dance and creative therapies)</td>
</tr>
<tr>
<td>- Counselling/therapy for partners</td>
<td>- Longer group treatment opportunities</td>
</tr>
<tr>
<td>- Services that accept male survivors as a priority</td>
<td></td>
</tr>
<tr>
<td>- Therapists with a strong understanding of CSA</td>
<td></td>
</tr>
<tr>
<td>- Specialised practitioners to help</td>
<td></td>
</tr>
<tr>
<td>- Feeling empowered by the therapy</td>
<td></td>
</tr>
<tr>
<td><strong>Non-therapeutic needs</strong></td>
<td><strong>Non-therapeutic needs</strong></td>
</tr>
<tr>
<td>- Advertising campaigns that target men to seek help and support</td>
<td>- Maternal bonding with children programs</td>
</tr>
<tr>
<td>- Change in expectations about masculine behaviour</td>
<td>- Maternal care programs</td>
</tr>
<tr>
<td></td>
<td>- Medical examinations that empower women rather than place them in a position that could be powerless or humiliating, pertinent for gynaecological examinations</td>
</tr>
</tbody>
</table>

Sources: Crete & Singh (2015); Quadara, Higgins, Nagy, Lykhina, & Wall (2013); Barber (2012); Astbury (2006).

Addressing the “cycle of abuse” myth

Adult male victims of child sexual abuse often cite concerns of stigmatisation for their reluctance to disclose (Barber, 2012), with many concerned that service providers, police and medical professionals may consider them to be offenders themselves (Price-Robertson, 2012). This is due to the incorrect belief that victims of CSA go on to offend against children in adulthood. This has also been referred to as the “cycle of abuse”. Research both in Australia and internationally has found no basis for this belief, as the majority of offenders have been found to have no history of CSA victimisation (Cutajar, Ogloff, & Mullen, 2011; Whitaker, Le, Hanson, Baker, McMahon, Ryan et al., 2008; Lisák, Hopper, & Song, 1996; Salter, McMillan, Richards, Talbot, Hodges, Bentovim, & Hastings et al., 2003; Jespersen, Lalumiere, & Seto, 2009; Widom & Ames, 1994).

It has been well documented that females are overwhelmingly victims of CSA; however, they only make up a very small minority of CSA perpetrators, thereby highlighting the largest inconsistency with the “cycle of abuse” theory. While members of the public may believe that there is such a cycle (Foster, Boyd & O’Leary, 2012), research is very clear that the cycle of abuse is not an applicable issue for supporting male victims of CSA. However, research does state that male victims of CSA, especially those aged 12 years and older at the time of their abuse, require support and therapeutic interventions. Ogloff, Cutajar, Mann, and Mullen (2012) demonstrated that boys who were sexually abused aged 12 years and over were more likely to be later convicted of a sexual offence than those who were 12 years and under when sexually abused, or never sexually abused. According to these authors it would suggest that psychosexual development is severely impacted by the abuse leading to the development of sexual offending in adulthood; however, as they note, they do not have the information for the possible explanations of this development (Ogloff et al., 2012).
Therapeutic and non-therapeutic support needs of minority populations

In relation to communities and populations that may sit outside of the mainstream populations, there is need for a more customised approach and cultural awareness across a range of activities—particularly in respect to crisis and long-term support of:

- Indigenous Australians;
- immigrant and refugee communities;
- GLBTIQ communities; and
- people with a disability.

Intersectionality describes the intersecting demographic features that make up an individual's identity. In the case of sexual abuse and assault, the intersection of being a woman, being of diverse sexuality to heterosexuality, having a disability or being Indigenous may increase their risk to sexual violence due to their social and physical location. It is vital to remain alert to issues of intersectionality in the response domain in order to account for difficulties and barriers that victim/survivors may have in accessing and maintaining engagement with support services, which may assist them to heal.

**Indigenous Australians**

Aboriginal and Torres Strait Islander children remain over-represented in child protection systems (Goldsworthy, 2015). There exist a range of issues that foster and maintain barriers to the reporting of child sexual abuse (and neglect), and indeed adult sexual assault, including:

- fear and mistrust of justice and government agencies;
- fear of racism;
- fear of removal of the child from the community;
- social and cultural pressure to protect the perpetrator from police violence and removal from their community;
- fear of the perpetrator and their family;
- shame, guilt and fear;
- non-recognition of child sexual abuse;
- cultural and language barriers to accessing relevant authorities; and
- a lack of reporting mechanisms in remote locations (adapted from Goldsworthy, 2015).

Hannah McGlade (2007) advocated the need for alternative forms of justice to address the sexual abuse and assault of Aboriginal children and women that prioritises “justice as healing”. McGlade (2007) has called for the justice system to develop responsiveness to the need for healing through legal mechanisms, in particular for the issue of child sexual abuse in Indigenous communities.

Service responses for Aboriginal and Torres Strait Islander adult victim/survivors of sexual abuse and assault are also affected by the issues outlined above. Fear of authority and of having the perpetrator removed from the community can be an important factor in under-reporting for this population. Fear that their kin and community might find out may also drive a lack of disclosures. Ongoing marginalisation and racism play a strong role in the intergenerational trauma and grief experienced by Indigenous people (Human Rights and Equal Opportunity Commission [HREOC], 1997). It is important to be victim-centred, flexible and consultative in relation to service provision with this population who may:

- choose to only work with Indigenous counsellor/advocates;
- choose to not work with Indigenous counsellor/advocates;
- feel more welcome in a service that meets their cultural needs;
- require workers to do outreach work in their community rather than travel to services and maintain appointment times; and
- require additional support for complex needs associated with alcohol and drug use, gambling, inadequate housing and legal difficulties (Anderson & Wild, 2007).
Therefore, diverse staffing, ongoing cultural awareness training (Closing the Gap Clearinghouse, 2013) and an acknowledgement of the disadvantage Aboriginal and Torres Strait Islander people experience in Australian society become the basis for providing services to this under-served population. More research and evaluation of programs will help build the evidence base for what works in responding appropriately to Indigenous disadvantage (Closing the Gap Clearinghouse, 2013).

**Immigrant, refugee and CALD communities**

Allimant and Ostapiej-Piatkowski (2011) outlined the practical implications for CALD, immigrant and refugee women who experience sexual abuse and trauma. In particular, they suggested some of the key issues to consider when providing support services:

- Support services will need to be alert to ethno-specific cultural values and diverse understandings of sexual violence (e.g., non-recognition of rape within marriage).
- Women need to be listened to in a confidential and non-judgemental setting (e.g., taking care to not implicitly judge another culture).
- Women who have experienced sexual assault, violence and torture may have limited capacity to deal with everyday challenges related to settlement, education and family, let alone accessing therapeutic support.
- Practitioners may like to focus on assisting victim/survivors to cope with trauma memories and flashbacks.
- Practitioners need to be alert to the use of inappropriate translators from within the community, which could potentially jeopardise the safety and privacy of victim/survivors.

**GLBTIQ communities**

In providing responses to sexual violence to gay, lesbian, bisexual, trans, intersex and queer communities, it is important to understand that non-heterosexual identity can be “denigrated, stigmatised or denied” (Mason, 1993, p. 2), leading to increasing risk of sexual violence and traumatic response. Some key concerns for GLBTIQ people in seeking to access services are:

- concern that they will be met with homophobic or heterosexist responses from service providers;
- fear that violence that occurs in a same-sex relationship will not be taken seriously;
- fear of not knowing if a service is welcoming and sensitive to the needs of people with diverse sexual identities; and
- lack of provision of GLBTIQ services and supports in regional and remote locations (adapted from Fileborn, 2012).

**People with a disability**

There is increased understanding that people with a disability are more likely to experience violence in their life then people without a disability (OurWatch, 2016a). Enabling disclosures and providing an appropriate response requires the promotion of the idea that all people, including people with a disability, have the right to live their lives free from sexual assault and violence (Murray & Powell, 2008).

Residential and community settings require policies and procedures that make clear the actions required in cases of disclosure, which may entail the comprehensive training of all professionals working with this population including police and support services (Murray & Powell, 2008). Educating people with a disability about sexuality may work to empower them to disclose should an abuse occur, and education may act as a preventative measure; however, responsibility to stop the abuse should never be placed on the shoulders of the victim.

Although the issue of “siloing” is not particular to the support needs of people with a disability who have experienced sexual abuse or assault, it impacts quite substantially on this population of people
(Murray & Powell, 2008). An integrated response across disability and sexual assault services, police and legal actors may support people with a disability to receive the support they want whether that be legal, therapeutic, or non-therapeutic.

**Therapeutic and non-therapeutic needs of secondary victims or non-offending family members**

Secondary victims of adult and child sexual assault can include family of the victim (non-offending parents in cases of CSA, parents, caregivers, extended family, siblings (both biological and non-biological), friends, partners and children (Fuller, 2016). Secondary victims have been defined as “persons who, though not the primary victim of crime, have suffered some form of vicarious trauma as a result” (Fuller, 2015).

Currently, the research has primarily focused on secondary victimisation of service workers, psychologists and others working with victims of sexual violence rather than on other individuals who offer the victim support. Although the effects of positive parental support in cases of CSA is well-documented (Corcoran, 2004; Cyr, Wright, Toupin, Oxman-Martinez, McDuff, & Theriault, 2002; Godbout, Briere, Sabourin, & Lussier, 2014), the effect of CSA on non-offending parents and other family members is not as well known. The research suggests that parents of children who have experienced child sexual abuse can experience feelings of:

- anxiety about the parental role, particularly in relation to:
  - lack of control in enabling safe spaces for their child/ren;
  - intense feelings of guilt (this is particularly true for mothers who are primary carers); and
  - the impact of knowing about sexual abuse on survivors’ siblings.

- an altered view of their child’s future—the abuse can become the key lens through which parents view issues such as:
  - concern about how their child will negotiate psycho-social developmental milestones such as puberty, sex and early relationships;
  - the loss of “normal” experiences (e.g. not wanting to sleep over at someone’s house);
  - risk of compromised schooling and educational outcomes (Quadara, Stathopoulos & Carson, 2016).

These impacts on parents, and particularly mothers, can be heightened if the abuse is intra-familial. The therapeutic and non-therapeutic needs of parents whose children have experienced institutional and/or extra-familial child sexual abuse was the subject of a qualitative study undertaken for the Royal Commission into Institutional Responses to Child Sexual Abuse (and whose findings may cautiously be extrapolated to parents whose child has experienced any type of child sexual abuse). They found that parents:

- were understandably focused on supporting the victim/survivor rather than seeking support for themselves;
- found the costs associated with support services punitive—sometimes choosing to forgo counselling themselves, even in the face of great need;
- wanted to engage with peer support groups so they could speak freely about their child’s experience and the impact on their family;
- were let down because of the lack of understanding from their community; and
- required easily accessible and helpful legal advice (Quadara et al., 2016).

Ongoing research about how non-offending parents are affected by CSA disclosure by their children is required.

It is known that non-perpetrator male partners of adult female victims are affected by disclosures of sexual assault (Daane, 2005) but as Morrison, Quadara, and Boyd (2007) noted, where secondary victims of sexual assault are considered more broadly by research literature it is primarily to examine how their responses affect the victim/survivor. The majority of literature about secondary victims of sexual violence centres on heterosexual male partners of female victim/survivors (where the woman
was victimised or survived CSA and/or adult sexual violence) (Daane, 2005; Morrison et al., 2007); however, participant numbers in studies tend to be quite low. This focus on male partners as secondary victims stretches back to early research into secondary victimisation, suggesting that early researchers may also have assumed that the effects of rape would be felt most strongly by male sexual partners due to traditional notions of sexual ownership (Morrison et al., 2007). Knowledge about the effects of secondary victimisation on same-sex partners of victim/survivors is limited and requires more research.

Domain 3: Policing and legislative responses to victims of sexual abuse and assault, and perpetrators

Research with sexual assault service providers and victim/survivors of adult and child sexual violence indicates that victim/survivors often feel re-victimised by the criminal justice system from their initial contact with police, through the investigation, and throughout the trial process (Kennedy & Easteal, 2011). For victim/survivors, perpetrators and the rest of the community, the criminal justice system is “one of the important community resources used to address [the] problem” (Murphy, Banyard, Maynard, & Dufresne, 2011). Therefore, secondary and tertiary responses from the criminal justice system are closely tied to responding to sexual violence.

Research into the justice needs of victim/survivors of sexual abuse and assault indicate the following are needed:

- information—about the various processes entailed in reporting and appearing in court;
- validation—to be believed by the criminal justice system;
- voice—to have their day in court and to tell their story;
- control—receiving regular updates about their case and being provided access to advocates to support decision-making (adapted from Clark, 2010).

Research across multiple jurisdictions in Australia indicates that although law reform and court practice reforms have sought to address the needs of victim/survivors in their experiences of court, it is suggested that there is a “clear need for ongoing education of legal and non-legal actors with respect to the social context(s) of sexual assault” (Bluett-Boyd & Fileborn, 2014).

For the majority of victim/survivors, whether as adults or children, their first interaction with the criminal justice system when disclosing is with the police. It is this first contact that can have a large impact on whether a victim/survivor chooses to continue their cooperation with the police. As noted by crisis support workers, victim/survivors may feel unsupported by the police not only due to the tone of questioning that is often employed (e.g., asking the victim what clothes they were wearing, what was their relationship with the accused like), but also due to any firearms the officers are wearing at the time of interviewing, which can appear threatening to the victim (Murphy et al., 2011).

The continued focus on the victim and attempting to find inconsistencies with the victim’s narrative can lead to emotional fatigue, which has been noted as a large reason why victims will choose not to proceed with their case (Murphy et al., 2011). Due to this, and victim/survivor and non-offending family members’ statements regarding feeling re-victimised or confused by the proceedings inherent to reporting a crime and the resulting investigation, many jurisdictions around the world and in Australia have introduced specialist investigative teams who concentrate on adult and child sexual assault. Table 6 outlines the specialist groups available in Australian jurisdictions.
Table 6: Specialist sexual violence teams

<table>
<thead>
<tr>
<th>Australian Capital Territory</th>
<th>Sexual Assault and Child Abuse Team (SACAT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Also has a Sexual Assault Victim Liaison Officer who helps victims navigate the criminal justice system by keeping them informed of the progress of the investigation and criminal proceedings</td>
</tr>
</tbody>
</table>

| New South Wales               | Most reported cases handled by local detectives. In cases of serious or serial sexual assault the Sex Crime Squad may be called in to assist. |
|                              | In cases of Child Sexual Abuse the Joint Investigation Response Squad (JIRS) will be involved in the investigation of the report. |
|                              | Individuals can also inform police about the assault via a Sexual Assault Questionnaire that gives details of the offence to the police but does not constitute a formal complaint. |

| Northern Territory            | No specific police team for child sexual abuse or sexual violence. |

| Queensland                    | Specialist Queensland Police Service (QPS) investigators |

| South Australia               | No specific police team for child sexual abuse or sexual violence. There is a Family Violence Investigation Team that investigates sexual violence committed within a familial environment. |

| Tasmania                      | No specific police team for child sexual abuse or sexual violence. Sexual abuse may be investigated if part of a broader enquiry into child abuse and neglect within a family also contending with family violence. The program is called Safe at Home. |

| Victoria                      | Sexual Offences and Child Abuse Investigation Teams (SOCIT) |
|                              | Specially trained and experienced detectives who deal exclusively with investigating sexual violence. |
|                              | Multidisciplinary Centres (MDC) |
|                              | Comprised of SOCIT team, Department of Human Services Child Protection, and CASA (Centres Against Sexual Assault) counsellors/advocates. Currently three in Victoria, with a further three to be established. Aim is to help reduce attrition and help victims with receiving aid. |

| Western Australia             | Sex Assault Squad |
|                              | Child Abuse Squad |

While all the police services of Australian states and territories offer information for members of the public about reporting sexual offences to them, and offer links to victim support services, there do not appear to be multi-agency centres outside of Victoria and the ACT that work in collaboration on a day-to-day basis with a set team. Evaluation of the Victorian model has found that victims have responded positively to the change, that the victim-focused model resulted in victims not feeling stigmatised, judged or re-traumatised by the experience, and the model aligned with what victims felt the police and investigators should be like towards victims of sexual violence (Powell & Cauchi, 2013). Evaluation of ACT’s Sexual Assault Reform Program found that, for victims, the introduction of fast-tracked testimony, the ability to give testimony away from the court, inter-agency training for service providers and reducing the amount of time the victim is required to spend as part of the criminal justice system resulted in a more positive experience with the criminal justice system (Anderson, Richards, & Willis, 2013).
Sexual Assault Response Teams (SART)
Sexual Assault Response Teams (SART) have been increasingly used across jurisdictions in the United States and Canada. SARTs bring together key stakeholders from within a community—police, prosecutors, medical/forensic examiners and rape victim advocates—in order to improve responses to sexual assaults. According to the research, there are mixed results regarding the effectiveness of SARTs (Greeson, Campbell, Bybee, & Kennedy, 2016). The reason for the differences in efficacy of the SART model across various communities is linked to there being “no one standardised, evidence-based SART model … tested and then adopted by practitioners. Rather communities tried different ways of collaborating and their ideas spread, leading to other communities reinventing the SART model in their own community” (Greeson et al., 2016, p. 281). Although SART practitioners claim to be driving their local programs according to best practice, SARTs that adhere to formal structures, are engaged in more institutionalisation of multidisciplinary trainings that are supported by research, formally evaluate their programs and institute these changes based on evaluation outcomes are more successful than where these practices are not established (Greeson et al., 2016). Although results are highly dependent on individuals working within SARTs, and adherence to the original SART model, research indicates that engaging multiple stakeholders associated with adult and sexual assault care through one team similar to the SART program is effective for victim/survivors and non-offending family members engaging with the criminal justice system (ALRC, 1997). This initiative has been recommended for Victoria in the past (1995) but was never implemented (ALRC, 1997). However, there are interagency protocols in place in all states and territories that outline how health care and other service providers should respond to sexual assault victims. Table 7 outlines these guidelines.
Table 7: Guidelines for how health and other service providers respond to sexual assault victims

<table>
<thead>
<tr>
<th>Jurisdiction and document title</th>
<th>Parties to guidelines</th>
<th>Applies to</th>
<th>Forensics and training</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales: Interagency Guidelines for Responding to Adult Victims of Sexual Assault (2005)</td>
<td>NSW Police, NSW Health, NSW Office of the Director of Public Prosecutions (ODPP), NSW Rape Crisis, Multicultural Agencies and Aboriginal Services and Victims support agencies such as the Victims of Crime Bureau</td>
<td>Adult victims of sexual violence</td>
<td>NSW Health offers preventative and educational programs for workers and communities. Forensic examination undertaken by Sexual Assault Services doctors/ NSW Health</td>
</tr>
<tr>
<td>Queensland: Interagency Guidelines for Responding to Adult Victims of Sexual Assault Statewide Guidelines (2002)</td>
<td>Queensland Health including public hospitals, GMOs, GPs and a network of specialist sexual assault services—government and NGO. Queensland Police Service Office of the DPP, also Department of Families, Department of Aboriginal and Torres Strait Islander Policy, Office for the Adult Guardian and Legal Aid Queensland.</td>
<td>Applicable within the context of non-consensual sexual activity between adults and apply to those victims aged 16 years and over.</td>
<td>GMO provides regular training to police on forensic and medical aspects of sexual assault and also to the DPP upon request. Sexual assault services also provide training. Forensics examiner is the Government Medical Officer (GMO).</td>
</tr>
<tr>
<td>Western Australia: Management of Alleged Recent Sexual Assault: Information for Metropolitan Emergency Departments (2003). SARC Manual and local inter-agency protocols or agreements for rural and remote (undated).</td>
<td>(2003) This document is a guide to metropolitan Emergency Departments (EDs) and their interaction with Perth SARC. The SARC has no ED facilities for medical, psychiatric or obstetric emergencies.</td>
<td>(2003) 13 years and over for medical and or forensic assessment if the alleged assault occurred less than 2 weeks ago. If the assault was more than 2 weeks ago and medical issues have been addressed, victim/survivors are referred to the 24-hour SARC counselling line.</td>
<td>(2003) Sexual Assault Resource Centre, Perth, organises training on a needs basis and according to calls from police for additional training. Forensic examination undertaken by SARC doctor.</td>
</tr>
<tr>
<td></td>
<td>(undated) Department of Community Development</td>
<td>(undated) All victim/survivors of sexual assault</td>
<td>(undated) Often a sole social worker at a hospital. SARC doctor can walk rural/remote doctor through process of forensic examination and forensic collection.</td>
</tr>
<tr>
<td>Location</td>
<td>Program/Services</td>
<td>Population</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tasmania:</td>
<td>Data has been difficult to collect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria: Standards of Practice for Victorian Centres Against Sexual Assault (2015)</td>
<td>Victorian Institute of Forensic Medicine (VIFM), Victorian Centres Against Sexual Assault (CASAs), Royal Children's Hospital—Gatehouse Centre, Monash Medical Centre, Child Protection Unit, South Eastern Centre Against Sexual Assault (SECASA).</td>
<td>All victims of sexual assault and child sexual abuse</td>
<td>Training in responding to sexual assault is delivered by most Victorian CASAs by arrangement with local agencies and police in their regions. Forensic training is provided by VIFM and includes an academic program delivered through Monash University.</td>
</tr>
<tr>
<td>Northern Territory:</td>
<td>A coordinated approach to better respond to Drug-Facilitated Sexual Assault in Darwin Urban (known as the &quot;toxicology protocol&quot;). Darwin urban area. (2004).</td>
<td>Children and adults</td>
<td>Provided by Darwin SARC. In respect of the &quot;toxicology protocol&quot; to CIB and new police recruits, Darwin hotel staff. Generally to CIB and new police recruits and Community Development training. Forensics undertaken by SARC rostered doctors, all of whom are women.</td>
</tr>
<tr>
<td>ACT: Sexual Assault Reform Program (2007)—Wraparound process</td>
<td>DPP, Australian Federal Police, ACT Justice and Community Safety Directorate, Canberra Rape Crisis Centre, Legal Aid, Forensic and Medical Sexual Assault Centre, Victims of Crime Coordinator</td>
<td>Adults</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Ollie, L. (2005).
Preventing re-victimisation in a legal context

As with adult sexual assault, there have been increasing efforts to ensure that child victims of sexual abuse are not re-victimised. Research indicates that children who have been sexually victimised are at an increased risk of subsequent harm both in childhood and later on in adulthood (Cutajar, Mullen, Ogloff, Thomas, Wells, & Spataro, 2010; Wall & Quadara, 2014). This has driven efforts to prevent re-victimisation. As Table 7 outlines, some Australian jurisdictions have specific teams for investigating child sexual abuse. Across many English-speaking countries (including Australia) it is now common to video or audio record children’s interviews in cases of sexual abuse disclosure to police in order to prevent ongoing traumatisation (ALRC, 1997), and to allow these recordings to be admissible as evidence in the courtroom.

Research with victim/survivors and their experiences with the judicial system have indicated that encountering the following incidents during their trial have made their experience traumatic:

- being able to see the accused;
- being cross-examined by the accused (if they are self-representing);
- having traumatised questions asked of them;
- arduous tests of their credibility;
- having to give evidence multiple times;
- giving evidence in an open court; and

Carmody’s (2006) work with crisis centre advocates found that adult sexual assault victim/survivors were often frustrated when criminal cases did not progress even when prosecutors appeared to be caring for the victim and wanting the ideal outcome for the survivor and the case. In order to attempt to counter the negative experiences of victim/survivors, states and territories have introduced legislation to support victim/survivors based on government reviews.

Table 8 gives the name of the original act in which the crime of sexual violence is dealt with, followed by legislative changes and amendments made that address the issues that victim/survivors have raised regarding their experiences in the courtroom.

Table 8: Sexual violence legislation and criminal justice evidence amendments

<table>
<thead>
<tr>
<th>ACT</th>
<th>Crimes Act 1900 (ACT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Original legislation covering sexual offences</td>
</tr>
<tr>
<td></td>
<td>Sexual and Violent Offences Legislation Amendment Act 2008</td>
</tr>
</tbody>
</table>

- Introduces allowances for audio or visual recording between police and the victim to be admissible as evidence for all sexual assault victims at committal hearing
- Cross-examination of non-disabled, adult victims who are considered vulnerable to be kept to a minimum
- Use of CCTV possible
- Restrict the victim’s view of the accused
- Prohibit the cross-examination of a victim by a self-represented accused
- Allow support people for victims to be present when presenting evidence
- Closure of the court to the public in certain circumstances

8 This literature review has considered government reviews conducted since 2005.
<table>
<thead>
<tr>
<th>Region</th>
<th>Act</th>
<th>Details</th>
</tr>
</thead>
</table>
| New South Wales | Crimes Act 1900 (NSW)                                 | Original legislation covering sexual offences  
Child Protection (Offenders Registration) Amendment (Statutory Review) Act 2014  
- Expands list of offences that can be registered  
- Criteria created to decide if individual is a risk to children’s safety  
Crimes Legislation Amendment Act 2014  
- Extends definition of attempted sexual assault  
Victims Rights and Support Act 2013  
- New victim support scheme  
- Approved counselling services  
- Financial assistance  
Crimes Legislation Amendment Act 2012  
- Expands category of offenders for sexual assault of child under special care  
- Extends definition of sensitive evidence to audio recordings  
Crimes (Sentencing Procedure) Amendment Act 2010  
- Court cannot take into account that offender is not allowed to work with children  
- DPP must show certificate that victim and police have been consulted re. charges negotiation with accused  
Criminal Procedure Amendment (Child Sexual Offence Evidence Pilot) Act 2015  
- Further provision for children giving of evidence in courts for sexual offences (operates till March 2019) |
- Currently debating to reduce the impact of court proceedings on vulnerable witnesses/ children  
- Based on Little Children are Sacred report (2007)  
- Allow pre-recording of evidence so they do not need to be in court  
- Apply across all courts in NT to cover all sexual offences  
- Unrepresented defendants cannot question the victim |
- Evidence of a child under the age of 16 years be taken in an environment that limits trauma  
- Limit the circumstances for when a child needs to present evidence in person at a committal hearing in court  
- Allow evidence to be pre-recorded  
- Allow evidence to be given via videolink |
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Legislation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence Act 1977 (s 21A)</td>
<td></td>
<td>Under this Act sexual assault victims can be considered “special witnesses” who can give evidence via video or audio link if proceedings are likely to traumatisethem.</td>
</tr>
</tbody>
</table>
| South Australia       | Criminal Law Consolidation Act 1935 (SA)                                    | **Criminal Law Consolidation (Rape and Sexual Offences Amendment) Act 2008**  
- Tightening of rules regarding cross-examination of witnesses  
- Distribution of evidence restricted (e.g. in cases of explicit photographs) to prevent re-victimisation |
| Tasmania              | Criminal Code 1924 (Tas.)                                                   | Evidence (Children and Special Witnesses) Act 2001  
Allows for children and special witnesses to give evidence via audio visual linking, a support person, exclusion of people from the courtroom. A person may classify as a special witness if they:  
- have an intellectual, mental or physical disability  
- an inability to give evidence in the ordinary manner  
- have a relationship to any party in the proceedings that would cause the victim emotional trauma, intimidation or distress that would prevent them from giving evidence satisfactorily. |
| Victoria              | Crimes Amendment (Sexual Offences and Other Matters) Act 2014 (Vic.)        | - Six distinct offences (rape; rape by compelling sexual penetration; sexual assault; sexual assault by compelling sexual touching; assault with intent to commit a sexual offence; threat to commit a sexual offence)  
- Sexual assault replaces indecent assault  
- New jury directions about consent: additions to directions about person withdrawing consent, or not giving clear consent  
- Accused belief in consent clarified  
- Intoxication of accused considered but kept to a high standard so as to not be used as an easy excuse  
- New charge to deal with failure to address repeated sexual offending  
- Clarification of laws around sexting  
- New offence of threatening to distribute intimate images  
- New offence of distributing intimate images without consent |
| Western Australia     | Criminal Code Act Compilation Act 1913 (WA)                                 | Evidence Act 1906 (2003 Amendment)  
- Sexual history of victim could not be adduced or introduced for defendant  
- Sexual experience of the victim cannot be introduced  
- If evidence considered to cause emotional trauma then can be a special witness and give evidence via video |
| Commonwealth          | Crimes Legislation Amendment (Law Enforcement Integrity, Vulnerable Witness Protection and Other Measures) Act 2013 (Cth) | - Allows children and vulnerable witnesses to give evidence via video link |
All jurisdictions have different laws around evidence of prior sexual experience of the victim. The leave of the court must be obtained in all jurisdictions except NSW to admit this evidence (in NSW the evidence can be admitted under certain circumstances (ALRC, 2010)). In Victoria, Tasmania, Western Australia and the Northern Territory, prior sexual relations between the victim and the accused cannot be introduced in evidence, and in the remaining jurisdictions recent sexual activity between the victim and the accused may be permitted in evidence (ALRC, 2010).

Restorative justice

Increasingly jurisdictions in Australia and around the world have introduced restorative justice practices for adult sexual assault and child sexual abuse cases. According to Julich and Bowen (2015), restorative justice is the preferred alternative response to sexual offending for many victims, not to replace the adversarial system but to run concurrent to it in cases where the accused pleads guilty. Sexual violence service workers are of the opinion that the adversarial nature of the criminal justice system is not geared towards the needs of the victim (Julich, 2010) but restorative justice practices allow victims to have a voice and are given a chance to articulate the effect that the offence had on them (Julich & Bowen, 2015).

Not all research is optimistic about restorative justice, as some are concerned that the risks for re-traumatisation are too high (Cossins, 2008). A meta-analysis of restorative justice programs for child sexual abuse and adult sexual assault found 15 programs attached to criminal justice systems and 29 programs independent of criminal justice systems worldwide (Bolitho & Freeman, 2016).

In Australia, there were two specific program linked to the criminal justice system. One was the New South Wales Pre-trial Diversion of Offenders program, also called “Cedar Cottage”, which was in operation between 1989 and 2014. The focus at Cedar Cottage was on restorative justice by bringing victim/survivors and their family members together with the offender. Although evaluated as being highly successful, the Cedar Cottage program was defunded in 2014 (Goodman-Delahunty, 2009, 2014; Goodman-Delahunty & O’Brien, 2014). The other Australian program was the South Australian Family Conferencing program. It is aimed at young offenders who plead guilty prior to sentencing and accept responsibility for their actions.

Of the 15 programs attached to criminal justice systems, 80% were found to meet the needs of victims and offenders in the aftermath of serious crimes (Bolitho & Freeman, 2016). Conditions for restorative justice being successful include:

- specialisation of facilitators, including skills, knowledge and experience of working with victim/survivors;
- vigilant use of screening (suitability of perpetrator for programs, not just eligibility);
- use of experts (in sex offending and the dynamics of violence);
- flexibility and responsiveness of participant needs;
- timing of the meeting is appropriate to victim/survivor readiness; and
- the offender receives targeted sex offender treatment (Bolitho & Freeman, 2016).

Table 9 includes the names of the 15 restorative justice programs linked to and/or mandated by the criminal justice systems. Table 10 lists a selection of sex offender treatment programs.
Table 9: Restorative justice practices linked to criminal justice systems

<table>
<thead>
<tr>
<th>Program</th>
<th>Jurisdiction</th>
<th>Offender/Victim participation</th>
<th>Offence types</th>
<th>Eligibility and referral</th>
<th>Point of contact</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Australian Family Conferencing</td>
<td>South Australia, Australia</td>
<td>Young offenders, victims invited</td>
<td>Sexual offences</td>
<td>Admission of guilt. Referrals made by police and youth courts</td>
<td>Pre-sentencing</td>
<td>Young Offenders Act 1993</td>
</tr>
<tr>
<td>Project Restore Specialist Sexual Violence Service</td>
<td>New Zealand</td>
<td>Adult or youth offenders, victim or victim advocates</td>
<td>Sexual offences with there being no concern of safety between victim and offender</td>
<td>Guilty plea at court. Offenders must be assessed for treatment and be treated if that is the outcome of the restorative justice. Police or court referral.</td>
<td>Pre and post-sentencing.</td>
<td>Victims' Rights Amendment Act (2014), Ministry of Justice’s Restorative Justice Standards for Sexual Offending Cases (2013)</td>
</tr>
<tr>
<td>Community Holistic Circle Healing program</td>
<td>Hollow Water, Manitoba, Canada</td>
<td>Adult offenders and the victim(s)</td>
<td>Inclusive of adult and child sexual assault</td>
<td>Guilty plea at court</td>
<td>Pre-sentencing</td>
<td>N/A</td>
</tr>
<tr>
<td>Victim Offender Conferencing, Restorative Justice Unit, Corrective Services NSW</td>
<td>New South Wales, Australia</td>
<td>Adult offenders and victim must be in attendance</td>
<td>All forms of serious crime</td>
<td>Conviction, no outstanding court matters, still being actively managed by Corrective Services NSW (offender is either in prison or on</td>
<td>Post-sentencing</td>
<td>N/A</td>
</tr>
<tr>
<td>Program</td>
<td>Location</td>
<td>Eligible Offenders</td>
<td>Offender Program Type</td>
<td>Referral</td>
<td>Legislation</td>
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<tr>
<td>Cedar Cottage Pre-Trial Diversion Program (no longer operational)</td>
<td>New South Wales, Australia</td>
<td>Adult offenders, victims encouraged</td>
<td>Intra-familial CSA</td>
<td>Guilty plea at court. Agreement to undergo treatment</td>
<td>New South Wales Pre-Trial Diversion of Offenders Act 1985 (regulation lapsed in 2012 but can be reactivated by Attorney-General)</td>
<td></td>
</tr>
<tr>
<td>Family Group Decision Making Demonstration Project (no longer operating)</td>
<td>Newfoundland, Labrador, Canada</td>
<td>Offenders within a family structure, victims</td>
<td>Child neglect and CSA</td>
<td>Referred by child welfare, parole, youth corrections and probation staff</td>
<td>Pre-court</td>
<td></td>
</tr>
<tr>
<td>RESTORE (Responsibility and Equity for Sexual Transgression Offering a Restorative Experience) (no longer operating)</td>
<td>Arizona, USA</td>
<td>Adult offenders. Doesn't proceed without a victim</td>
<td>Felony and misdemeanor sexual offences</td>
<td>Offender accepts responsibility (but doesn't have to plead guilty). Referral via prosecutor</td>
<td>Pre-court diversion</td>
<td></td>
</tr>
<tr>
<td>Collaborative Justice Program</td>
<td>Ottawa, Canada</td>
<td>Adult or youth offenders. Victim must be in attendance.</td>
<td>Various crimes including sexual ones</td>
<td>Guilty plea. Referrals made by Victim/Witness Assistance Program, the Investigating Officer or the Crown</td>
<td>Pre and post sentencing.</td>
<td></td>
</tr>
<tr>
<td>Program</td>
<td>Country</td>
<td>Participants</td>
<td>Crime Types</td>
<td>Referral Process</td>
<td>Post-sentencing</td>
<td>Law/Policy Reference</td>
</tr>
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</tr>
<tr>
<td>Community Justice Initiatives Association’s Victim Offender Mediation Program (VOMP)</td>
<td>British Columbia, Canada</td>
<td>Adult offenders and victims</td>
<td>Violent crime including sexual violence</td>
<td>Referrals made by offenders and victims</td>
<td>Post-sentencing, usually post prison</td>
<td>N/A</td>
</tr>
<tr>
<td>Restorative Opportunities</td>
<td>Canada</td>
<td>Adult offenders, victims or victim representatives</td>
<td>Violent crime including sexual violence</td>
<td>Offender takes responsibility. Referrals made by prison staff.</td>
<td>Post-sentence.</td>
<td>Correctional Service Canada Commissioner’s Directive 785</td>
</tr>
<tr>
<td>Victim Offender Sensitive Dialogue</td>
<td>Texas and Ohio, USA</td>
<td>Adult offenders and victims</td>
<td>Violent crime including sexual violence</td>
<td>Offender admits guilt and takes responsibility. Referrals can only be made by victims.</td>
<td>Post-sentencing (in prison or afterwards)</td>
<td>Ohio—State of Ohio Victim Offender Dialogue Policy, Office of Victim Services (2014)</td>
</tr>
<tr>
<td>ACT Police Youth Diversion (subsumed into new scheme)</td>
<td>ACT, Australia</td>
<td>Young offenders, victims invited</td>
<td>Vary</td>
<td>Referred by police</td>
<td>Pre-sentence</td>
<td>N/A</td>
</tr>
<tr>
<td>Northern Ireland Youth Conferencing Scheme</td>
<td>Belfast, Northern Ireland</td>
<td>Young offenders, victims invited</td>
<td>Most offences, except offences with mandatory life sentences</td>
<td>Referrals made by court or prosecution</td>
<td>Pre-sentence</td>
<td>Justice (Northern Ireland) Act 2002</td>
</tr>
<tr>
<td>Mana Restorative Justice Program</td>
<td>New Zealand</td>
<td>Offenders, doesn’t proceed without victim in attendance</td>
<td>Intimate partner violence</td>
<td>Guilty plea at court. Referral made by victim, offender, lawyer, court, police or judge</td>
<td>Pre-sentence</td>
<td>Victims’ Rights Amendment Act (2014), New Zealand Ministry of Justice’s Restorative justice Standards for Family Violence</td>
</tr>
<tr>
<td>Circles of Peace</td>
<td>Arizona, USA</td>
<td>Offenders, victims invited</td>
<td>Domestic and family violence</td>
<td>Court-referred via sentencing</td>
<td>Post-sentencing</td>
<td>Arizona Department of Health Service policy</td>
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</tbody>
</table>

Source: Adapted from Bolitho & Freeman (2016), pp. 22–24.

### Table 10: A selection of sex offender treatment programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Circles of Support and Accountability</strong></td>
<td>Originally from Canada. Focus on community reintegration of offenders. Group therapy: one offender, five members of community. Results indicate that 70–83% lower chance of reoffending if COSA circle is strong (Finkelhor, 2009; Wilson, Cortoni, &amp; McWhinnie, 2009). Currently under trial in South Australia.</td>
</tr>
<tr>
<td><strong>Integrated Treatment</strong></td>
<td>In-prison treatment—semi-structured, cognitive behavioural approach, emotional expression and regulation. Based on successful processes employed by therapists. Not evaluated.</td>
</tr>
<tr>
<td><strong>Good Lives</strong></td>
<td>Treatment for offenders. Offending is understood within a broader concept of unmet needs and frustrations of the offender. Focus is on building the offender’s self-esteem, self-confidence and sense of hope. Works not only with sexual offenders but other serious crimes as well. Adult and youth offenders. Evaluations find it very successful.</td>
</tr>
</tbody>
</table>

Source: Adapted from Quadara et al. (2015).
Domain 4: Training and capacity building for services responding to child sexual abuse and adult sexual assault

The majority of professional development, organisational and in-school training about sexual violence service provision and responding to disclosures of sexual abuse is offered by sexual assault services around Australia. This is similar to the situation internationally. Training in both Australia and around the world is offered for medical professionals (midwives, doctors, nurses), psychologists and counsellors, teachers, youth workers, support workers in government agencies and members of the public who may have victim/survivors as friends or relatives in need of their care (Eogan et al., 2013).

Services (such as police, medical and mental health) need to offer trauma-informed care to victims of sexual assault (adult and child); that is, to consider the sensitivities and vulnerabilities of individuals who have undergone a traumatic event or ongoing experience (Astbury, 2006; Ko et al., 2008; Plichita, Vandecar-Burdin, Odor, Reams, & Zhang, 2006; Wall, L., Higgins, D., & Hunter, 2016). It has been argued that trauma-informed care needs to be offered as standard practice by health care professionals due to the unique position that they are in to recognise and identify victims of sexual assault even if an individual is not presenting for sexual victimisation services (Astbury, 2006).

While sexual violence services offer the training, research indicates that the uptake of the opportunity to receive training from sexual violence services can be irregular. Over 80% of emergency departments in the state of Virginia do not offer ongoing training for their doctors and nurses in forensic examination of sexual assault victims (Plichita et al., 2006), and more recent research indicates that only one-fifth of hospitals in the USA offer comprehensive care for sexual assault victims that would include offering appropriate forensic medical examinations and support following an attack (Patel et al., 2013).

A review of sexual assault management and practices in Western Australian hospitals found that doctors and nurses in remote and rural areas do not have training in forensic examinations, there are few culturally appropriate services available in hospitals, and often medical staff are unaware of how to deal with victims and sexual assault within the legal system (Jancey, Meuleners, & Phillips, 2011). Although sexual assault services are offering training for medical staff, nurses and doctors are reporting that they are not receiving any training, though they express that these training services are very beneficial to their ability to offer patients appropriate treatment when they do receive them (Maier, 2012; Patel et al., 2013; Plichita et al., 2006).

Training for police members

Police service personnel receive education about sexual violence during their initial training, and there is increasing use of specialist investigation units across Australia to exclusively investigate sexual crimes. There has also been interest in, and in some cases the development of, interagency guidelines for work across sexual assault services and the police forces. Spiranovic (2011), however, has noted that there is still a lack of training regarding sexual assault and violence in the police forces of New South Wales, Victoria and the Australian Capital Territory. While training (which may not be identical for all teams within a jurisdiction) is available and ongoing for police personnel who are part of specialist child sexual abuse teams, there is a lack of training (or knowledge about whether training is available and what that training involves) for non-specialist personnel. Gaps in the training include a lack of sensitivity training (towards victims), and with interviewing and reporting skills (Spiranovic, 2011). Similar issues have been noted in Western Australia (Community Development and Justice Standing Committee, 2008).

Evaluations of the “whole of story” method of interviewing child sexual abuse victims, which is employed by specialist investigators of CSA in Victoria, are available with very positive research findings (Barnett, 2013). Evaluations of police sexual assault training are scarce.
(Kinney, Bruns, Bradley, Dantzler, & Weist, 2007), with the majority of research available coming from the United States (Taylor, Bradley, Muldoon, & Norma 2012). Self-report studies from police officers in Boston noted that while they all remembered receiving sexual assault training during their time in formal training, they were told to forget this by supervisors and learn on the job (Stevens, 2006).

There appears to be no research information about the education and training of Australian police officers on adult sexual assault (Taylor et al., 2012). Work with both adult and child survivors of sexual assault has indicated that the term “complex trauma” perhaps better encompasses the range of symptoms and impacts of victimisation on an individual’s mental and physical wellbeing both in the short and long-terms (Briere & Spinazzola, 2005; Kezelman & Stavropoulos, 2012; Quadara, 2015).

**Trauma-informed training**

Due to this, there has been increased attention on how to provide trauma-informed and trauma-specific training to services and their personnel who interact with victim/survivors. Mental health practitioners in Victoria, for example, note that while they are aware that they handle the cases of women who may have been sexually victimised, and they are aware of the long-term detrimental effects of sexual violence on survivors, they do not receive the training or support in sexual assault awareness to make them comfortable in talking to victim/survivors about their histories of sexual abuse (McLindon & Harms, 2011). Trauma-informed care has received greater support and attention in the USA and Europe to date, with it being very underdeveloped as a theory governing service provision in Australia (Quadara, 2015).

Trauma-informed care considers how the history and impact of trauma (or multiple instances of trauma) could be (and should be) used to inform the treatment the individual receives as well as how the individual is interacted with at organisational levels of all services they may seek out when receiving treatment (Quadara, 2015). Trauma-specific training and care, on the other hand, refers to the interventions used to treat the trauma (e.g. cognitive behavioural therapy, eye movement reprocessing and desensitisation). Being trauma-informed does not only mean that the service is aware of the history of sexual victimisation but rather that the entire organisation within which a service sits and operates out of (including management) is modified in lines with what is known about how the lives of survivors change following trauma, and how they may be triggered or re-traumatised by interaction with a service (Quadara, 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015; Wall, Higgins, & Hunter, 2016). There are selected characteristics of services, organisations and institutions that are trauma-informed systems. Characteristics include:

- providing safety for the client from physical harm and re-traumatisation;
- an understanding of clients and their symptoms within the context of their life experiences, histories, and cultures;
- open communication and collaboration between the service provider and the client throughout service delivery at all levels;
- focusing not on symptom management but on skill building;
- understanding how symptoms of trauma may be attempts to cope;
- viewing trauma not as a one-off event but a defining experience that permeates and can be the core of an individual’s identity; and
- focusing on what has happened to the client rather than what is “wrong” with them (Jennings, 2004).

It has been argued that all services, not only sexual assault services, should be trauma-informed, and that a level or history of trauma should be expected when interacting with individuals seeking services or where services are interacting with general members of the public (e.g., the police force) (Kezelman & Stavropoulos, 2012). It is estimated that at least 25% of children and adolescents experience at least one traumatic event during their lifetime (including accidents,
maltration, assault and violence) (Costello, Erkanli, Fairbank, & Angold, 2002) and this can have long-term consequences for many (Pynoos, Steinberg, Schreiber, & Brymer, 2006).

The effects of the traumatisation are often noticed within the school setting; however, it is individuals such as first responders (police, firefighters, paramedics) who may have the largest effect on diminishing the immediate effects of trauma when they encounter survivors (Ko et al., 2008). The effects of the trauma can also be mitigated in non-offending family members of the child by police officers who can understand and attend to the needs of victims and their family members (Ko et al., 2008). Service personnel who have received training about the needs of traumatised children are also able to provide links with the necessary health care professionals for the family more readily then those who are unaware of mental health and other trauma-specific services (Ko et al., 2008). This does not mean that the suggestion is for all service personnel (police, firefighters, medical staff in hospitals, teachers or mental health staff for instance) to be experts in the field of trauma but that there be enough training in place to make them aware of how to help traumatised individuals (for a description of the role and function of trauma-aware organisations and trauma-informed care, see Wall et al., 2016).

Snapshot of sexual assault training programs

Table 11 outlines currently available training programs for individuals working in government and non-government funded organisations who want to receive training about sexual violence. The table also illustrates how trauma-informed practice is presented to certain services and why the training focuses on sexual violence trauma. Some programs claim to be trauma-informed and focused on helping individuals learn about trauma-informed care, others present information about sexual violence and the traumas associated with it.

As a point of note about the programs presented in Table 11, there is no publically available information on the program sites about evaluations or whether or not these programs represent “best practice”. The program operators may use the term “best practice”; however, they do so without indicating any evaluations of their programs, or what aspects of their programs represent “best practice”. Services that are not specifically sexual violence services or linked with sexual violence services offering training are not included in the table. Non-sexual violence services include ones such as the Lighthouse Foundation who are focused on youth and homelessness; they offer a variety of training programs that individuals working with sexual assault victims may be able to utilise. Some of these programs have been provided through the Royal Commission into Institutional Responses to Child Sexual Abuse. Training seminars are offered in areas such as:

• understanding complex trauma and trauma informed practices;
• a trauma-informed approach to understanding grief and loss;
• understanding and working with trauma-based behaviour;
• understanding psychosocial development;
• promoting a sense of belonging;
• therapeutic group process; and
• preventing vicarious trauma in the workplace.

Details included in Table 11 may not convey all of the currently available programs that sexual assault service providers offer to other service staff. The table is dependent upon freely available information via service and government agency websites. An indepth examination of currently available training programs would require communication with individual services to receive information about training they offer to service personnel.

The services listed below may receive government funding to run their programs (e.g., programs associated with NSW Health indicate that they are somehow government funded) but information is unclear. The training courses that are listed below are recurring workshops, seminars or other training opportunities offered by service providers or organisations. Organisations such as the Australian Association for Social Workers (AASW) and the Australian Community Workers Association (ACWA) offer numerous one-off training days for
professionals wishing to develop their skills; however, there is no guarantee that these will be repeated beyond a single session or into the future. For this reason they have been excluded from this table. Where organisations such as AASW and ACWA offer sexual assault or child sexual abuse specific training these tend to be organised and run by sexual assault services in the given state; for example, in Victoria it is CASA (Centres Against Sexual Assault) who run training sessions, and these are their recurring training sessions. The Australian and New Zealand Association for the Treatment of Sexual Assault (ANZATSA) will run training seminars throughout the year (for 2016 there is only one running according to their website). These courses will repeat and are sexual assault and child sexual abuse specific and therefore have been included below.
<table>
<thead>
<tr>
<th>Name of program</th>
<th>Location</th>
<th>State</th>
<th>Type of sexual violence</th>
<th>Training type</th>
<th>Socio-ecological level</th>
<th>Settings of program</th>
<th>Populations targeted</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Development Project</td>
<td>AUS</td>
<td>Vic.</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>Individual</td>
<td>26 days of training on a range of topics per year</td>
<td>Sexual assault service personnel</td>
<td>Run by CASAs in Vic.</td>
</tr>
<tr>
<td>Various</td>
<td>AUS</td>
<td>Vic.</td>
<td>SXA/CSA</td>
<td>Crisis/Other</td>
<td>Individual/ Organisational/ Community</td>
<td>Professionals in sexual assault and CSA services</td>
<td>ANZATSA (Australian and New Zealand Association for the Treatment of Sexual Abuse) presented. Workshops and conferences. Details on website: &lt;www.anzatsa.org/index.php?page=Training_Events&gt;</td>
<td></td>
</tr>
<tr>
<td>Provision of medical care &amp; forensic services to adults who have been raped or sexually assaulted</td>
<td>AUS</td>
<td>SA</td>
<td>SXA (adult)</td>
<td>Crisis</td>
<td>Individual</td>
<td>3-day training run by Yarrow Place</td>
<td>Medical personnel</td>
<td>Available to all doctors in Australia, 3 days of training with understanding context of SXA, medical issues including child protection, impacts of CSA on adults and DV, writing medico-legal reports, giving evidence in court, forensic aspects of SXA care, being an expert witness in court</td>
</tr>
<tr>
<td>Program</td>
<td>Country</td>
<td>Region</td>
<td>CSA and child abuse</td>
<td>Program Type</td>
<td>Training Details</td>
<td>Professional Description</td>
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<tr>
<td>Graduate Certificate in Developmental Trauma</td>
<td>AUS</td>
<td>Vic., NSW, NT, SA</td>
<td>CSA and child abuse</td>
<td>Other</td>
<td>Individual 22 face-to-face training days, individual participant support and application in the workplace</td>
<td>Australian Childhood Foundation. Only nationally accredited vocational qualification dealing with trauma in Australia. Since 2010.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Modality Course: Dyadic Developmental Psychotherapy or Sensorimotor Psychotherapy</td>
<td>AUS</td>
<td>Vic./ NSW</td>
<td>CSA and child abuse</td>
<td>Other</td>
<td>Individual/Family DDP is an 8-day face-to-face course, with assessment. SPI is a 12-day face-to-face course.</td>
<td>Australian Childhood Foundation. SPI has three levels of courses available. DDP is a brain-based attachment model around the neuroscience of care giving and therapeutic parenting and care.</td>
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</tr>
<tr>
<td>Stress and Trauma in Young Children</td>
<td>AUS</td>
<td>Vic.</td>
<td>CSA and child abuse</td>
<td>Other</td>
<td>Individual Half-day workshop</td>
<td>Australian Childhood Foundation. Focus on impact of trauma on brain development and understanding consequences of stress on children’s cognitive, social and emotional development. Supported by Department of Education and Training Victoria. Offer 25 workshops in regional and metro areas per year.</td>
<td></td>
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</tr>
<tr>
<td>SMART (Strategies for Managing Abuse Related Trauma)</td>
<td>AUS</td>
<td>SA, Tas., NT, &amp; Catholic Education schools</td>
<td>CSA and child abuse</td>
<td>Other</td>
<td>Individual/ Organisational</td>
<td>Tailored to individual schools— programs schools participate in Action Research to measure impacts for children and YP</td>
<td>Schools— professionals and children</td>
<td>Australian Childhood Foundation. Operational for 6 years. Stated in conjunction with Indigenous Health Unit at Monash University and Child Abuse Prevention Research Australia. Individual counselling and support available for individual children and not just whole school community.</td>
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</tr>
<tr>
<td>Organisation training</td>
<td>AUS</td>
<td>All</td>
<td>CSA and child abuse</td>
<td>Other</td>
<td>Individual/ Organisational</td>
<td>Workplaces</td>
<td>Organisations working with children</td>
<td>Australian Childhood Foundation. Each workshop is tailored to needs of organisation. Sessions can include information about neurobiology of trauma, infant experience of trauma, creative and therapeutic strategies for children affected by abuse, trauma assessment frameworks.</td>
</tr>
<tr>
<td>Recognising and responding to disclosures of sexual abuse</td>
<td>AUS</td>
<td>SA</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>Individual/Organisations</td>
<td>Training course</td>
<td>Service personnel</td>
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</tbody>
</table>

From website: Equip participants with the knowledge, skills and attitudes necessary to provide appropriate responses to adults who have been raped or sexually assaulted. This involves an understanding of the context in which rape and sexual assault occurs; the ability to assess client needs and match them to services available; and supporting the rights of clients through the implementation of practices which promote client self-determination. Training and Education Seminars can be provided for organisations on site. Specific courses in Counselling, Trauma Informed Care, and Supporting Aboriginal Families and Communities are also offered on request.
<table>
<thead>
<tr>
<th>Responding to Disclosures</th>
<th>AUS</th>
<th>Qld</th>
<th>CSA (child V/S)</th>
<th>Other</th>
<th>Individual</th>
<th>3-hour workshop</th>
<th>People who have contact with children</th>
</tr>
</thead>
</table>

Bravehearts. From website: specifically designed to teach what steps to take when responding to a child who has experienced or may be at risk of experiencing child sexual assault. The workshop will provide participants with a brief overview of the nature of child sexual assault addressing myths and common misperceptions. Training will also cover emotional and behavioural indicators of harm, symptoms of the trauma associated with child sexual assault, offenders and offending behaviour. Half of the workshop’s duration will be spent on how to best respond to a disclosure and the process of reporting to the relevant child protection authorities and the police.
<table>
<thead>
<tr>
<th>Responding to Disclosures: Teachers and Educators</th>
<th>AUS</th>
<th>Qld</th>
<th>CSA (child V/S)</th>
<th>Other</th>
<th>Individual</th>
<th>6-hour workshop</th>
<th>Teachers and those working in schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>From website: This workshop is specifically tailored to teachers and child care educators designed to develop their skills in responding to a child who has experienced or may be at risk of experiencing child sexual assault. The workshop will provide participants with a brief overview of the nature of child sexual assault expelling the many myths surrounding the topic. It will go through some of the indicators of harm, other forms of childhood abuse and neglect and symptoms of childhood trauma. The workshop explores offenders and offending behaviours, including the grooming cycle and risk factors associated with at-risk children. A large portion of the training is spent on how to appropriately respond to a child's disclosure and the process of reporting to the relevant child protection authority and the police. In addition one module of the training covers age appropriate sexual development (up to and including 12 years) and what can be defined as problem sexual behaviour in children. Finally, the training concludes with an overview of the 13-piece “Ditto in a Box” preventative education program that makes “being safe” simple to teach in a classroom or child care environment and other resources that are available from Bravehearts to educators working with children. This workshop is extremely interactive and encourages group participation, discussion and resources to utilise within school or child care environment.</td>
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</tr>
<tr>
<td>Course Title</td>
<td>Location</td>
<td>Target Audience</td>
<td>Duration</td>
<td>Instructors</td>
<td>Notes</td>
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<tr>
<td>Responding to Disclosures: Foster carers and support workers</td>
<td>AUS Qld</td>
<td>CSA (child V/S)</td>
<td>Individual</td>
<td>7-hour workshop</td>
<td>Foster carers in addition to teachers and educators workshop it also deals with vicarious trauma. Also for youth workers, residential care workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner workshop—working with Child Sexual Assault</td>
<td>AUS Qld</td>
<td>CSA (child V/S)</td>
<td>Individual</td>
<td>2-day workshop</td>
<td>Psychologists, social workers Content as of other Bravehearts workshops for teachers, carers and parents.</td>
<td></td>
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<tr>
<td>Online training</td>
<td>AUS</td>
<td>CSA (child V/S)</td>
<td>Individual</td>
<td>Online</td>
<td>Foster carers, psychologists, teachers, social workers Content as of other Bravehearts workshops for teachers, carers and parents.</td>
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<tr>
<td>Child sexual assault for Aboriginal Workers</td>
<td>AUS NSW</td>
<td>CSA (child V/S)</td>
<td>Individual/ Community</td>
<td>3-day course</td>
<td>Aboriginal workers from government and community sectors From website: There will be opportunities to yarn about the complexity of dealing with this issue in community as well as working in a culturally safe way that places child protection at the centre of the work. Focus on understanding offenders and how they interact with families, resp. of different agencies, identify indicators and effects of CSA in Aboriginal communities.</td>
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<tr>
<td>The sexual assault of Aboriginal boys &amp; men: A 3-day workshop</td>
<td>AUS NSW</td>
<td>SXA (adult)</td>
<td>Individual/ Community</td>
<td>3-day course</td>
<td>Aboriginal and non-Aboriginal workers helping and supporting Aboriginal men and boys To learn about the range of issues experienced by Aboriginal boys and men who have been sexually assaulted</td>
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<tr>
<td>JIRT Aboriginal Community Engagement Workshop—What to do if a child discloses sexual abuse</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (child V/S)</td>
<td>Other</td>
<td>Individual/ Community</td>
<td>Workshop</td>
<td>Aboriginal workers, Aboriginal community members, non-Aboriginal workers working within Aboriginal communities</td>
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<tr>
<td>Interpreting for people who have experienced sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>Individual</td>
<td>2-day workshop</td>
<td>Interpreters</td>
</tr>
<tr>
<td>Putting child protection on the radar: A course for NSW Health sexual assault workers</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (child V/S)</td>
<td>Other</td>
<td>Individual</td>
<td>3-day workshop</td>
<td>SXA service workers</td>
</tr>
<tr>
<td>Course Title</td>
<td>Country</td>
<td>State</td>
<td>Type</td>
<td>Level</td>
<td>Learning Mode</td>
<td>Duration</td>
<td>Target Audience</td>
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<tr>
<td>10355NAT Graduate Certificate in Medical &amp; Forensic Management of Adult Sexual Assault</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Crisis</td>
<td>Individual</td>
<td>Course. Face to face and blended learning</td>
<td>Doctors and nurses</td>
</tr>
<tr>
<td>Introduction to the medical and forensic management of adult sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Crisis</td>
<td>Individual</td>
<td>4 virtual classroom workshops</td>
<td>Doctors and nurses</td>
</tr>
<tr>
<td>Medical management of adult sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Crisis</td>
<td>Individual</td>
<td>One day face to face</td>
<td>Medical personnel working with NSW SAS</td>
</tr>
<tr>
<td>Utilising a trauma-informed framework in responding to child and adult sexual assault for mental health professionals</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)/ CSA</td>
<td>Other</td>
<td>Individual</td>
<td>3-day face-to-face workshop</td>
<td>Mental health staff (incl. medical, nursing, social work, occupational), case managers, community mental health workers, workers of psychiatric hospitals and accommodation services</td>
</tr>
<tr>
<td>Topic</td>
<td>Location</td>
<td>Type</td>
<td>Target Audience</td>
<td>Format</td>
<td>Participants</td>
<td>Focus of Program</td>
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<tr>
<td>Implementing safety from sexual assault and harassment in adult mental health inpatient units</td>
<td>AUS NSW</td>
<td>SXA (adult)</td>
<td>Other Individual</td>
<td>1-day workshop</td>
<td>Mental health staff and those working in acute inpatient facilities</td>
<td>Focus on the promotion of safety, the prevention of sexual assault as well as best practice in responding to disclosures of SXA when they occur in inpatient facilities. How to minimise re-traumatisation</td>
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</tr>
<tr>
<td>Implementing safety from sexual assault and harassment in adolescent mental health inpatient units</td>
<td>AUS NSW</td>
<td>CSA</td>
<td>Other Individual</td>
<td>1-day workshop</td>
<td>Mental health staff working in child and adolescent mental health facilities</td>
<td>Focus on the promotion of safety, the prevention of sexual abuse as well as best practice in responding to disclosures of SXA when they occur in inpatient facilities. How to minimise re-traumatisation</td>
<td></td>
</tr>
<tr>
<td>Adult and child sexual assault for consumer support workers</td>
<td>AUS NSW</td>
<td>SXA/CSA</td>
<td>Other Individual</td>
<td>3-day workshop</td>
<td>Consumer support workers employed by NSW Health</td>
<td>Focus on the promotion of safety, the prevention of sexual abuse as well as best practice in responding to disclosures of SXA when they occur in inpatient facilities. How to minimise re-traumatisation</td>
<td></td>
</tr>
<tr>
<td>Part 1 NSW Health specialist sexual assault services training</td>
<td>AUS NSW</td>
<td>SXA/CSA</td>
<td>Other Individual</td>
<td>5-day workshop/ 3-weekly programs scheduled over the year to allow time between training to integrate new learning into practice</td>
<td>Counsellors employed by NSW Health sexual assault services</td>
<td>Comprehensive introduction to working with people who have been sexually assaulted. Incl. socio-political context of SXA, interagency functioning, legal issues, crisis intervention, therapeutic approaches</td>
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<tr>
<td>Part 2 NSW Health specialist sexual assault services training</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/CSA</td>
<td>Other</td>
<td>Individual</td>
<td>5-day workshop/3-weekly programs scheduled over the year to allow time between training to integrate new learning into practice</td>
<td>Counsellors employed by NSW Health sexual assault services</td>
</tr>
<tr>
<td>Part 3 NSW Health specialist sexual assault services training</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/CSA</td>
<td>Other</td>
<td>Individual</td>
<td>5-day workshop/3-weekly programs scheduled over the year to allow time between training to integrate new learning into practice</td>
<td>Counsellors employed by NSW Health sexual assault services</td>
</tr>
<tr>
<td>JIRT Foundations skills courses</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/CSA</td>
<td>Other</td>
<td>Individual</td>
<td>2-week course delivered by NSW family and community services, NSW Health and NSW Police</td>
<td>JIRT senior health clinicians, other health workers who offer a JIRT response</td>
</tr>
<tr>
<td>Practice forum: Working with children under 10 with sexually harmful behaviours</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA</td>
<td>Other</td>
<td>Individual</td>
<td>2-day course</td>
<td>Those with current clinical experience in working with children with problematic sexualised behaviours and their families</td>
</tr>
<tr>
<td>Course Title</td>
<td>Location</td>
<td>Region</td>
<td>CSA (child V/S)</td>
<td>Duration</td>
<td>Target Audience</td>
<td>Description</td>
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<tr>
<td>Working therapeutically with children &amp; young people who have experienced child sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (child V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>Frontline workers and counsellors working with children and young people who have experienced CSA and other forms of abuse builds upon basic understanding of CSA. Counseling process is explored and ways in which to assist children and young people move away from effects of sexual assault.</td>
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</tr>
<tr>
<td>Sexual assault in the correctional environment</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/CSA victimisation</td>
<td>Long term</td>
<td>Individual</td>
<td>Justice health workers</td>
<td></td>
</tr>
<tr>
<td>Working with sexual assault: A course for NSW Health CPCS workers</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/CSA victimisation</td>
<td>Long term</td>
<td>Individual/ Families</td>
<td>NSW Health child protection counselling services workers</td>
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<td>Children and young people engaging with CPCS workers may be victims of CSA and dealing with effects, as may parents and carers of these children, which may influence their parenting. Focus on incidence of CSA and links with parenting of adult V/S of CSA, how to respond to disclosures (whether recent or historical). Invited to explore application of these learnings to current case practices.</td>
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<tr>
<td>Course Title</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Duration</td>
<td>Level</td>
<td>Length</td>
<td>Target Audience</td>
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<tr>
<td>Foundations of working with adults sexually assaulted as children</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>3-day course</td>
<td>NSW Health workers, counsellors in non-government organisations and counsellors in private practice</td>
</tr>
<tr>
<td>Who can a man tell? Working with men who have been sexually assaulted</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/ CSA</td>
<td>Long term</td>
<td>Individual</td>
<td>3-day course</td>
<td>Health, welfare counsellors and other support staff working with men</td>
</tr>
<tr>
<td>Responding to people with a disability who have been sexually assaulted</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/ CSA</td>
<td>Long term</td>
<td>Individual</td>
<td>3-day course</td>
<td>Sexual assault, child protection, disability and general practitioners</td>
</tr>
<tr>
<td>Overview of dialectical behaviour therapy (DBT) in responding to people with complex trauma</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA/ CSA</td>
<td>Long term</td>
<td>Individual</td>
<td>1-day course</td>
<td>Counsellors employed by NSW Health sexual assault services and their interagency partners</td>
</tr>
<tr>
<td>Holding the frame: advanced therapeutic work with adult survivors of child sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>3-day course</td>
<td>Counsellors providing therapeutic services to adults</td>
</tr>
<tr>
<td>Group work with adults sexually assaulted as children</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>2-day course</td>
<td>Counsellors working with adults who have been sexually assaulted as children</td>
</tr>
<tr>
<td>In the shadow of the offender</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (child V/S)</td>
<td>Crisis</td>
<td>Individual/Families</td>
<td>3-day course</td>
<td>NSW Health workers, counsellors in non-government organisations and counsellors in private practice</td>
</tr>
<tr>
<td>Working therapeutically with children &amp; young people who have experienced sibling sexual assault</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (child V/S)</td>
<td>Crisis</td>
<td>Individual/Families</td>
<td>3-day course</td>
<td>Counsellors working with children and young people who have experienced sibling sexual abuse. NSW Health workers only</td>
</tr>
<tr>
<td>Working with families around sexualised behaviours of their children (aged under 10)</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA</td>
<td>Other</td>
<td>Individual/Families</td>
<td>3-day course</td>
<td>Counsellors employed by NSW Health in SAS, CPSC, child and family teams, Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>Sexual assault for Victims Services staff</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>Individual</td>
<td>- day course</td>
<td>Victims Services staff</td>
</tr>
<tr>
<td>Course Title</td>
<td>Country</td>
<td>State</td>
<td>Language</td>
<td>Demographic</td>
<td>Duration</td>
<td>Objectives</td>
<td>Description</td>
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<tr>
<td>Unveiling Shame: Therapeutic practices with children, YP, and adults impacted by shame, a legacy of violence and abuse</td>
<td>AUS</td>
<td>NSW</td>
<td>Other</td>
<td>Individual</td>
<td>2-day course</td>
<td>Counsellors employed by NSW Health, non-government organisations working with children, YP and adults in relation to SXA, DV, CSA and child abuse and neglect</td>
<td>Explores burden of shame carried by victims; clinical perspectives that reveal shame's existence, connection to the dynamics and legacies of abuse and ongoing effects</td>
</tr>
<tr>
<td>Responding with Compassion</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>1 to 3 hours</td>
<td>Frontline staff in health and welfare services to respond when someone discloses</td>
<td>Rape and Domestic Violence Services Australia. Myths and realities of SXA; SXA incidences; dos and don'ts of SXA responses. Length of session depends upon what individuals choose. Not training in SXA counselling</td>
</tr>
<tr>
<td>Complex Training</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Other</td>
<td>4 hours</td>
<td>SXA frontline workers</td>
<td>Rape and Domestic Violence Services Australia. Designed to assist those who work with traumatised people to understand these symptoms, and to develop effective ways of responding to the challenging behaviours.</td>
</tr>
<tr>
<td>Understanding Vicarious Trauma—Workshop 1</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA</td>
<td>Other</td>
<td>4 hours or 7 hours</td>
<td>Frontline and other staff to help them respond to vicarious trauma</td>
<td>Rape and Domestic Violence Services Australia. Training available on arrangement.</td>
</tr>
<tr>
<td>Course Title</td>
<td>Location</td>
<td>Region</td>
<td>Delivery</td>
<td>Duration</td>
<td>Description</td>
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<tr>
<td>Responding Vicarious Trauma—Workshop 2</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA</td>
<td>Individual</td>
<td>4 hours or 7 hours Frontline and other staff to help them respond to vicarious trauma Rape and Domestic Violence Services Australia. Training available on arrangement. Prerequisite is Workshop 1</td>
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<tr>
<td>Supervising the management of Vicarious Trauma</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA</td>
<td>Other</td>
<td>4 hours Frontline and other staff to help them respond to vicarious trauma Rape and Domestic Violence Services Australia. Training available on arrangement. Prerequisite is Workshop 1. For making effective strategies for managing vicarious trauma in the workplace</td>
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<tr>
<td>Crisis intervention for traumatised people</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA</td>
<td>Crisis</td>
<td>1-day course Counsellors Rape and Domestic Violence Services Australia. To assist counsellors use the crisis intervention model of RDV to respond to clients in crisis</td>
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<tr>
<td>Trauma Specialist Counselling</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>10 days Telephone counsellors Rape and Domestic Violence Services Australia. Building capacity of counsellors to help respond to those affected by Royal Commission in the short, medium and long term</td>
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<tr>
<td>Telephone Counselling</td>
<td>AUS</td>
<td>NSW</td>
<td>SXA (adult)</td>
<td>Crisis</td>
<td>1 or 2 days Telephone counsellors Rape and Domestic Violence Services Australia. Building capacity of counsellors who are telephone counsellors. Minimum 3 years of experience counselling. Degree in psychology, social services needed</td>
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<td>Course Title</td>
<td>Location</td>
<td>Level</td>
<td>Target Audience</td>
<td>Duration</td>
<td>Prerequisites</td>
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<tr>
<td>Working with children who have experienced sexual assault</td>
<td>AUS</td>
<td>Long</td>
<td>Individual</td>
<td>1-day</td>
<td>Those working with adults who were victims of CSA</td>
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<tr>
<td>Working with the impacts of sexual assault</td>
<td>AUS</td>
<td>Long</td>
<td>Individual</td>
<td>2-day</td>
<td>Those working sexual assault survivors</td>
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<tr>
<td>Competent responses to Aboriginal sexual and family violence</td>
<td>AUS</td>
<td>Long</td>
<td>Individual/Family</td>
<td>3-day</td>
<td>Non-Aboriginal workers in CPSC, sexual assault, drug, DFV, women's health,</td>
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<tr>
<td>Schema Therapy—SARC</td>
<td>AUS</td>
<td>Other</td>
<td>Individual</td>
<td>2-day</td>
<td>People working in volunteering in government, non-government and private</td>
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<tr>
<td>Counselling skills in working with adolescents who have experienced trauma—SARC</td>
<td>AUS</td>
<td>Other</td>
<td>Individual</td>
<td>1-day</td>
<td>Nurses, pastors, school counsellors, teachers, youth workers, allied health</td>
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<tr>
<td>Responding to Disclosures Self Care and Vicarious Trauma for Workers—SARC</td>
<td>AUS</td>
<td>Crisis</td>
<td>Individual</td>
<td>1-day</td>
<td>Aboriginal workers</td>
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<tr>
<td>Course Title</td>
<td>Location</td>
<td>Course Type</td>
<td>Target Audience</td>
<td>Description</td>
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<tr>
<td>Basic Trauma Counselling— SARC</td>
<td>AUS WA</td>
<td>SXA/CSA Other Individual</td>
<td>1-day course</td>
<td>People working in volunteering in government, non-government and private organisations Interactive workshop to provide overview of theoretical underpinnings of trauma work and strategies for use in trauma counselling</td>
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<tr>
<td>Imagery rescripting— SARC</td>
<td>AUS WA</td>
<td>CSA Other Individual</td>
<td>1-day course</td>
<td>Unknown Use of imagery rescripting to treat childhood related PTSD and use of schema therapy</td>
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<tr>
<td>Vicarious Trauma and Self Care for Workers—SARC</td>
<td>AUS WA</td>
<td>SXA/CSA Other Individual/ Organisations</td>
<td>1-day course</td>
<td>Workers in sexual assault services Knowledge in working with complex trauma, common issues for people with CSA/SXA.</td>
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<tr>
<td>Advanced Trauma Practice: Incorporating a Somatic Approach— SARC</td>
<td>AUS WA</td>
<td>SXA/CSA Other Individual</td>
<td>2-day course</td>
<td>Mental health professionals For women's health workers, counselling services; custom workshops for DV/FV workers Management of adolescents and adults following a sexual assault</td>
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<tr>
<td>SARC Presentations</td>
<td>AUS WA</td>
<td>SXA/CSA Other Organisations</td>
<td>1 hour</td>
<td>Workplaces Management of adolescents and adults following a sexual assault</td>
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<tr>
<td>Emergency Management of Sexual Assault— SARC</td>
<td>AUS WA</td>
<td>SXA/CSA Crisis Organisations</td>
<td>1/2 day training</td>
<td>Doctors and nurses Management of adolescents and adults following a sexual assault</td>
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<tr>
<td>Emergency Management of Sexual Assault: Regional and Remote Workers— SARC</td>
<td>AUS WA</td>
<td>SXA/CSA Crisis Organisations</td>
<td>1-hour video conference</td>
<td>Doctors and nurses Management of adolescents and adults following a sexual assault who present at regional hospitals</td>
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<tr>
<td>Course</td>
<td>Location</td>
<td>Region</td>
<td>Scope</td>
<td>Type</td>
<td>Duration</td>
<td>Target Audience</td>
<td>Description</td>
</tr>
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<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Clinical Forensic Training—SARC</td>
<td>AUS</td>
<td>WA</td>
<td>SXA/CSA</td>
<td>Crisis</td>
<td>Organisations</td>
<td>3-day course</td>
<td>Doctors and nurses, midwives. Skills and knowledge for medical staff on forensic examination, injury documentation, collection of forensic specimen for recent sexual assault.</td>
</tr>
<tr>
<td>Forensic Nurse Refresher Video Conference—SARC</td>
<td>AUS</td>
<td>WA</td>
<td>SXA/CSA</td>
<td>Crisis</td>
<td>Organisations</td>
<td>1.5-hour video conference</td>
<td>Nurses. For nurses who have done the 3-day forensic training to refresh knowledge. Discussion of real cases.</td>
</tr>
<tr>
<td>Living Well</td>
<td>AUS</td>
<td>QLD</td>
<td>CSA</td>
<td>Other</td>
<td>Individual</td>
<td>1-day workshop</td>
<td>Workers who may interact with men who have been victims of CSA. Organisation is Living Well. One-off workshops.</td>
</tr>
<tr>
<td>Trauma Informed Care—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Other</td>
<td>Individual</td>
<td>1-day workshop</td>
<td>Workers in medical environment, lawyers, employment services, housing, disability. Information and skills needed by workers in service settings.</td>
</tr>
<tr>
<td>Trauma Informed Care—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Other</td>
<td>Organisations</td>
<td>Half day</td>
<td>Anyone working in organisations incl. volunteers, administration, counsellors.</td>
</tr>
<tr>
<td>Trauma Informed Care—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Other</td>
<td>Individual</td>
<td>Half day</td>
<td>Managers in community mental health settings.</td>
</tr>
<tr>
<td>Trauma Informed Care—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Other</td>
<td>Individual</td>
<td>1-day course</td>
<td>For Aboriginal and Torres Strait Islander workers. Types and effects of trauma in ATSI community.</td>
</tr>
<tr>
<td>Supporting Adult Survivors of Complex Trauma—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Other</td>
<td>Individual</td>
<td>1-day course</td>
<td>Health professionals</td>
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<tr>
<td>Working therapeutically with people who have complex trauma histories—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>2-day course</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Identifying and responding to adult survivors of childhood trauma including abuse—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>2 hours</td>
<td>Primary care practitioners</td>
</tr>
<tr>
<td>Trauma informed clinical supervision for clinical supervisors—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>Half day</td>
<td>Counsellors and psychologists</td>
</tr>
<tr>
<td>Safeguarding yourself: Recognising and responding to Vicarious Trauma—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>1-day course</td>
<td>Health professionals, DV workers, case workers, disability workers, police, emergency workers</td>
</tr>
<tr>
<td>Educational workshop for carers, partners, friends and family of survivors of CSA—ASCA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>1-day course</td>
<td>Non-offending family and carers of survivors</td>
</tr>
<tr>
<td>Educational workshop for adults who have experienced childhood trauma and/or abuse—ASCANSA</td>
<td>AUS</td>
<td>NSW</td>
<td>CSA (adult V/S)</td>
<td>Long term</td>
<td>Individual</td>
<td>1-day course</td>
<td>Victim/survivors</td>
</tr>
</tbody>
</table>
References


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