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Issues paper 10: Advocacy and Support and Therapeutic Treatment Services

Dear Commissioners,

Thank you for the opportunity to provide a submission in response to Issues Paper 10 about Advocacy and Support and Therapeutic Treatment Services.

Our submission is informed by our detailed knowledge and experience of the systems in NSW for responding to child sexual abuse. It particularly draws on our experience in relation to our audit (between 2009 and 2012) of the implementation of the *NSW Interagency Plan to Tackle Child Sexual Assault* (Interagency Plan). Our Audit Report, *Responding to Child Sexual Assault in Aboriginal Communities*, details our audit activities, findings and recommendations – Chapter 10 focuses on issues in relation to counselling services.[1]

Our statutory role to audit the Interagency Plan under Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* concluded when our Audit Report was tabled in NSW Parliament in January 2013. We recommended that the NSW Government publicly report on its progress in responding to our recommendations within two years of the tabling of the report.[2] In June this year, the Minister for Family and Community Services provided us with the NSW Government's Progress Report and a copy was uploaded to the Family and Community Services' website.

While our audit focused on child sexual assault in Aboriginal communities, in doing so, we also put a spotlight on the capacity and effectiveness of a range of frontline services for all child sexual assault victims. Our report highlighted that addressing the complex issues faced in Aboriginal communities requires significant systemic change which will result in improved responses for all victims and survivors of child sexual assault. While it has been almost three years since our report was released, we are aware from our ongoing oversight of child protection and policing that the issues we highlighted – many of which are in the process of

[1] *Responding to Child Sexual Assault in Aboriginal Communities:* A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, NSW Ombudsman, December 2012, p. 101 – 115.
[2] Recommendation 91. *Responding to Child Sexual Assault in Aboriginal Communities:* A report under Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, NSW Ombudsman, December 2012, p. 285.

being addressed – continue to have currency in NSW. In this way, the report and the response to-date provides the Commission with a useful benchmark to assess the progress NSW has made in responding to a range of important systems issues which impact on the capacity to respond effectively to child sexual assault in Aboriginal communities and more widely.

Notwithstanding the conclusion of our formal monitoring role, we will continue to monitor the response to our recommendations in the course of exercising our broad statutory functions in relation to child protection and our ongoing role to audit the implementation of designated Aboriginal programs – the first of which is the NSW Government's Aboriginal affairs plan – OCHRE.

Rather than addressing all of the questions in the Issues Paper, our submission focuses on responding to those topics where we have particular insights or expertise through our work. Our submission covers the following topics:

- Diverse victims and survivors
  - Counselling and support for Aboriginal victims and survivors
  - Unreported and unsubstantiated matters
  - Adult survivors of child sexual assault
  - Services for adults in custody
  - Victims of intra-familial sexual assault
- Geographic considerations
  - Recruitment and retention
  - Outreach
- Service systems issues
  - Need for discretionary funds for SASs
  - Improving the coordination and provision of state-wide counselling services.

1. Overview of counselling resources

Sexual assault counsellors play a critical role in the coordination of responses for child and adult sexual assault victims, including 'arranging medical responses, providing crisis and ongoing counselling, support and court preparation.'[3] It is well accepted that the long term impact of trauma is reduced for those children and families who receive an immediate crisis response and counselling following a disclosure of abuse.[4]

At the time of our Audit Report the NSW Government provided access to sexual assault counselling for children through three main pathways, the:

- NSW Health Sexual Assault Service (SAS)
- Department of Justice 'Approved Counselling Service'
- Department of Family and Community Services (FACS) Child and Adolescent Sexual Assault Counselling (CASAC) services.

The SAS continues to be the most substantial service provider of its type in NSW, with greater coverage, and more capacity, than any other service. We understand funding for

[3] NSW Government, *Keep Them Safe: A shared approach to child wellbeing*, 2009, p.13.
[4] *Joint Investigative Response Teams Policy and Procedures Manual,* p.19.

CASAC services has been transferred to NSW Health and has been allocated to three Local Health Districts (Hunter New England, Mid North Coast and Central Coast) to administer.

Another critical part of the child sexual assault counselling landscape in NSW, is the Joint Investigation Response Team (JIRT) – the multi-agency vehicle for responding to child sexual abuse in NSW. The JIRT aims to provide a collaborative, interagency response to reports of serious child abuse through the joint investigation of cases by Police and Community Services, with support from NSW Health professionals. At the time of our report there were 22 JIRTs operating across NSW.[5] NSW Health formally became a JIRT partner in 2006 and during our audit it bedded down its initial JIRT workforce of 25 Senior Health Clinician positions[6] with responsibilities including the coordination of counselling referrals.

Over the last ten years, the shortage of sexual assault counsellors in NSW has been highlighted in numerous reviews and inquiries including:

- *Breaking the Silence: Creating the Future, Addressing child sexual assault in Aboriginal Communities in NSW* (June 2006), Aboriginal Child Sexual Assault Taskforce (ACSAT)
- *Special Commission of Inquiry into Child Protection Services in New South Wales*, November 2008
- *Keep Them Safe: A Shared Approach to Child Wellbeing 2009-2014,* March 2009, NSW Government
- *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities (2009 – 2011,* January 2007, NSW Government
- *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence services mapping. Final Report to NSW Department of Health,* February 2011, ARTD Consultants (the 'Health Counselling Review')
- *Responding to Child Sexual Assault in Aboriginal Communities:* A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, NSW Ombudsman, December 2012 (our 'Audit Report').

Our audit of the Interagency Plan included a review of the counselling services available for victims of child sexual assault in NSW. We found that for the majority of existing counselling services across the sector, there had been no funding enhancement over the five years of the Interagency Plan – 2006 to 2011. In addition, the data we obtained for our review showed that over the same period the NSW Health SAS appeared to be seeing more children. Local Health Districts told us that they were experiencing increased pressure to provide counselling to growing numbers of children but that this was at the expense of providing a comprehensive service.[7] At the same time the Joint Investigation Response Team (JIRT) was facing serious state-wide resourcing challenges.

Our Audit Report noted that while the JIRT was initially established with an equal number of police and Community Services officers, over subsequent years the resourcing attached to the CAS has increased substantially more than that of JIRT Community Services. The disparity

[5] At the time of the audit, the Bourke JIRT was a temporary unit. In line with recommendation 22 of our Audit report the Bourke JIRT is now permanent and receives recurrent funding.
[6] Most of these positions had been filled by December 2012.
[7] A detailed discussion of our findings in relation to the capacity of counselling services in NSW can be found in section 10.1 of *Responding to Child Sexual Assault in Aboriginal Communities:* A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, NSW Ombudsman, December 2012, p. 102 – 107.

was likely to become even greater given that the CAS was also under-resourced and needed increased resourcing to meet demand.

In response to our Audit Report, FACS conducted a review of its JIRT staffing and created an additional 10 caseworker positions. The NSW Police Force also expanded its Child Abuse Squad (CAS) by 30 officers at the time of our report. In March 2015, due in large part to the impressive results achieved by the CAS with its additional resourcing, funding for a further 50 CAS officers was announced and is being phased over in over four years.

Therefore despite the recent allocation of additional FACS caseworkers to the JIRT, if there are no further staffing enhancements to the FACS JIRT workforce by 2019, FACS will have around 100 fewer frontline staff allocated to the JIRT than the NSW Police Force allocation to the CAS, placing a significant amount of pressure on the capacity of Community Services to simultaneously address the safety requirements of a child while police are conducting a criminal investigation. The additional CAS resources will also have a significant impact on the capacity of the Health JIRT workforce to respond to demand for its services. We understand that 10 additional positions have been funded for the 2015/16 financial year and a further 12 positions are likely to be funded for 2016/17.

On a separate but related note, the NSW Health response to our recommendations[8] about improving access to forensic medical examinations and other sexual assault services has also been very positive. Targeted funding has been provided to enable rural and regional Local Health Districts to implement integrated sexual assault service models for children and adults that are tailored to local conditions.[9] These enhancements are encouraging. However, ongoing monitoring of capacity and demand will be required to ensure additional funds are directed to areas of greatest need, and are sufficiently flexible to allow Local Health Districts to respond to local conditions and needs.

2. Diverse victims and survivors

A key focus of our Audit Report was the capacity of services to meet the needs of children in Aboriginal communities. However, our report inquired into child sexual assault counselling more broadly and we found that the needs of a number of other groups were not being adequately met by current counselling arrangements, including clients with complex needs, children who had not made a formal disclosure to police or Community Services, adult survivors of child sexual abuse, and with the exception of a limited program being trialled at the time of our report, there were no dedicated services directed at sexual assault victims in custody.

Counselling and support for Aboriginal victims and survivors

Over the 5 years of the Interagency Plan, data showed reporting of sexual assault for Aboriginal children increased by 11.6%.[10] However, the number of sexual assault counsellors, and particularly Aboriginal counsellors, in NSW had not kept pace with increased reporting for a range of reasons.

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[8] *Responding to Child Sexual Assault in Aboriginal Communities:* A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, NSW Ombudsman, December 2012, p.133-134.

[9] NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, June 2015, pp13-14.

[10] For non-Aboriginal children reporting also increased but not to the same extent and over a longer period.

During our audit consultations we were told that insufficient counselling services can have a negative impact on the willingness of victims to come forward to report abuse. Actively supporting Aboriginal children and their families when they report sexual abuse helps build the community confidence necessary for increased reporting to continue.

Breaking the Silence identified a chronic shortage across agencies of counsellors and support staff able to respond to sexual assault in Aboriginal communities, including a shortage of Aboriginal staff. The Interagency Plan recognised this shortage and committed NSW Health to '...provid[ing] additional Aboriginal specialist child sexual assault counsellors' to help address the gap.[11]

In response NSW Health established seven additional designated Aboriginal child sexual assault counselling positions across three Local Health Districts in NSW.[12] In September 2012, this brought the total number of fulltime equivalent Aboriginal sexual assault counsellor positions across NSW Health to 8.5. These additional positions facilitated an increase in the engagement of Aboriginal children with the SAS, with two of the Local Health Districts reporting a significant increase in Aboriginal children receiving counselling from the SAS.[13] These results demonstrate the value of these dedicated roles and why investing in retaining and attracting Aboriginal staff to rural and remote locations should be seen as a priority. In this context, we noted in our Audit Report that it was disappointing that the impact of the new Aboriginal child sexual assault counselling positions on the rate of Aboriginal children receiving counselling in the relevant Local Health Districts was not being tracked by NSW Health. We recommended that Health improve data collection systems to address this. As we discuss below under 'service system issues', we understand that the new SAS data system will address our recommendations to improve a range of data collection issues.

The Interagency Plan also directed a number of agencies, including NSW Health, to enhance strategies to support, mentor and recruit Aboriginal staff. However, difficulties in recruitment and retaining Aboriginal staff, including issues of professional isolation, a lack of culturally appropriate supervision, and uncompetitive remuneration relative to other identified Aboriginal positions meant that a number of the new positions were vacant at the conclusion of our audit. In addition, lack of recurrent funding meant that the future of a number of the positions was insecure.

As with the recruitment of generalist positions, the nature of the work and the skills required of applicants significantly narrow the field of potential applicants for identified Aboriginal positions. In our consultations with NSW Health's Education Centre Against Violence (ECAV) and Aboriginal workers across the health and welfare sector, we were told that Aboriginal people will often not apply for positions with NSW Health because of prohibitive qualification criteria. Sexual assault counselling is a highly specialised and complex area, and it is critical that staff who are providing these services are appropriately trained and qualified. However, in order to build a highly skilled Aboriginal workforce in this area, it is essential that where recruitment attempts are unsuccessful, Local Health Districts have the capacity

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[11] NSW Government, *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011*, January 2007, p.20.

[12] Hunter New England Local Health District, Illawarra Shoalhaven Local Health District, Western Sydney Local Health District.

[13] From approximately 41 in 2007 to approximately 107 in 2011 in one Local Health District and from 17 in 2007 to 29 in 2011 in another.

(and funding) to implement flexible solutions, including mentoring Aboriginal staff into positions over a period of time.

During our audit we were advised of an innovative approach in one Local Health District, which re-aligned an Aboriginal Health Worker position into a sexual assault service role for a period of 12 months. This staff member was to be mentored by the Manager, Sexual Assault, and partnered with the Senior Sexual Assault Worker. We also noted that a number of Local Health Districts were implementing strategies to recruit Aboriginal staff, including developing an Aboriginal staff network and providing cultural supervision.

In the final stage of our audit NSW Health released its, *Good Health – Great Jobs, Aboriginal Workforce Strategic Framework 2011-2015,* which included a goal to increase the overall representation of Aboriginal people in the health workforce from 1.8% to 2.6%. The 2014 Progress Report[14] for the Strategic Framework revealed disappointing results including that NSW Health was 'not reaching the necessary growth per annum to achieve this target.'[15]

Our Audit report recommended[16] that NSW Health designate responsibility to the ECAV[17] for developing an Aboriginal recruitment and staff development plan with the specific aim of increasing the number of Aboriginal sexual assault counsellors across NSW. We recommended that such work should be undertaken collaboratively with the Public Service Commission (PSC) and we note that under OCHRE, the PSC is now developing a sector-wide approach to Aboriginal employment, leadership and career development. The *NSW Public Sector Aboriginal Employment Strategy 2014-2017* was released by the PSC in April 2015.[18] We also understand that in line with our recommendations on this issue new options are being developed by the NSW Government for the recruitment, retention and development of Aboriginal staff across all disciplines (not only sexual assault counsellors) in consultation with ECAV.[19]

In response to our audit recommendations, (then) NSW Kids and Families established a new Aboriginal Senior Policy Analyst position whose functions include the promotion of health equity for Aboriginal people and championing Aboriginal health in government initiatives addressing sexual assault, in collaboration with ECAV.[20] However, with the dissolution of Kids and Families from 31 October this year,[21] it is unclear where positions of this type will be located. As a transitional arrangement the 'Office of Kids and Families' is currently housed within the Health Administration Corporation, however, there appears to be no certainty at this stage, about the extent to which the current functions of the office will be dispersed or disbanded.

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[14] *Good Health–Great Jobs:* Key Performance Indicator Report January-June 2012, NSW Health, January 2014.
[15] *Good Health – Great Jobs, Aboriginal Workforce Strategic Framework 2011-2015,* Key Performance Indicator Report**,** January-June 2012, NSW Health, January 2014, p.13.
[16] See recommendation 27, NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 115.
[17] In consultation with the Ministerial Advisory Body on Aboriginal Child Sexual Assault and the Aboriginal Communities Matter Advisory Group established by ECAV.
[18] http://www.psc.nsw.gov.au/workplace-culture---diversity/equity---diversity/aboriginal-workforce/aboriginal-employment-strategy .
[19] Advice provided by NSW Health in implementation monitoring process.
[20] Advice provided by NSW Health in implementation monitoring process.
[21] *Health Services Amendment (NSW Kids and Families) Order 2015.*

Unreported and unsubstantiated matters

Our report also highlighted significant service gaps in relation to children who had been sexually abused but had not formally reported the allegation and had it substantiated (i.e. by JIRT, community services or police). The consultations we conducted raised significant concerns that due to competing priorities, counselling services were not widely available to children *suspected* of being sexually abused.

NSW Health's SAS is the primary vehicle through which it provides a response to children who have been sexually abused. The SAS also provides a service to adult victims of sexual assault. At the time of our review there were 55 SAS dedicated service response sites across NSW, as well as three SASs which were combined with child protection services.

Adults and children aged 14 and over can access the SAS through a number of different pathways. However, children under the age of 14 must be referred to the service as part of a formal investigation process. In most instances a referral to the SAS will only be accepted for a child under 14 where the sexual assault has been substantiated. As a result, a large number of children suspected of being sexually assaulted (but who did not receive a JIRT response), will not be guaranteed an offer of counselling by the SAS, particularly when resourcing constraints mean that many SASs have difficulty meeting demand for accepted JIRT matters. Even when a report has been made, any delays in the JIRT investigation process can also result in delays in referrals to the SAS.

Victims Services and Support, an agency within the Department of Justice, also provide counselling to adults and children who have been the victim of an act of violence, through the 'Approved Counselling Service.' The Victim Support Scheme[22] funds counselling of up to 22 hours to sexual assault victims (additional hours can be approved in exceptional circumstances). For victims of sexual abuse no time limit applies in relation to how long ago the sexual abuse occurred. Significantly, eligibility for counselling under the scheme is not contingent upon a formal report having been made or criminal proceedings having been commenced, although a victim is required to provide some form of substantiation that the abuse occurred in order to access counselling. Victims Services and Support plays a critical role in providing an alternative access point to counselling services for children and young people who have not made a formal report, although some form of substantiation that the abuse occurred is required in order to access counselling.

Our audit reported that of the more than 300 active 'approved' counsellors in the service more than half were also registered as having a specialty with Aboriginal clients.[23] The ECAV[24] and (then) Victims Services had teamed up to provide mandatory training as a pre-requisite for this Aboriginal specialty registration.[25]

At the time of our report, counselling was also available through CASAC services which are now funded by NSW Health. These non-government services provided a flexible long-term therapeutic response and most accepted referrals where there had been no formal report of the

[22] This scheme was introduced in June 2013 to replace the old Victims Compensation Scheme which was reviewed by *PricewaterhouseCoopers* for the Department of Attorney General and Justice in 2011: *NSW Department of Attorney General and Justice Review of the Victims Compensation Fund*.
[23] This included only two Aboriginal counsellors.
[24] ECAV has an extensive history in providing training to workers who deliver services to Aboriginal children and adults who have experienced sexual assault; domestic or family violence; and physical and emotional abuse and neglect.
[25] NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.104.

sexual assault, or where the assault has not been substantiated. Most CASAC services also provided services for adult survivors of child sexual assault. In other words, CASAC provided services to victims who did not meet the criteria for counselling under either the SAS or Victims Services and Support. CASAC services reported high demand, and we were advised that some services had waiting lists of up to two years. The transfer of funding for CASAC from Community Services to NSW Health may have some benefits in reducing complexity. However, it is unclear whether funding has continued for all 11 CASAC services which were operating at the time of our audit.

While it is possible for victims to self-refer to most CASAC services and to some other non-government services, these services were not widely available across NSW at the time of our audit. Access to private practitioners who are experienced in sexual assault can also be limited, and where these practitioners are available, there is generally a Medicare gap payment required, which renders the services unaffordable for many families.

Given their unique role and high demand, we are concerned that new funding arrangements continue to offer services to those victims and survivors of child sexual abuse who fall outside the eligibility criteria applied by other service providers.

Adult survivors of child sexual assault

Of the 49,299 reports of sexual abuse (adult and child) made over the life of the *NSW Interagency Plan to Tackle Child Sexual Assault*, 3,787 or 8% involved an adult reporting sexual abuse that occurred when they were a child. We understand anecdotally from police that reports of historical abuse have increased since the commencement of the Royal Commission.

SASs use a priority list of groups of clients to allocate the use of counselling services.[26] Notably, in the list of seven client groups, 'adults who have been sexually assaulted as a child' were listed as the lowest priority group. Given the capacity shortfalls of many SASs, most services report that they rarely work with this client group, despite significant evidence supporting the effectiveness of counselling.

Most SASs refer adult survivors of child sexual assault to the Approved Counselling Service, private practitioners, the Rape Crisis Centre, or to generalist NSW Health counsellors. Almost universally across the state, these services have a limited ability to meet demand. At the time of our audit, almost all of the Local Health Districts, including those in metropolitan areas, advised us that these services are not readily available, due to factors including a lack of providers, long waiting lists, and a lack of expertise in providing services to adult survivors of child sexual assault.

During our consultations with community members, a number of people highlighted the link between the availability of services for adult survivors and community attitudes to encouraging children to report sexual assault. In addition, a number of stakeholders spoke about women who had made the decision to come forward about the sexual assault that they experienced as a child in order to protect their own children from the same perpetrator. This highlights why the provision of services to this group is both important for the wellbeing and mental health of the adult clients themselves as well as to protect children from perpetrators

[26] NSW Health, *Sexual Assault Services Policy and Procedure Manual (Adult)*, May 1999, p.6.

who continue to live in the same community, or who may be part of the family or extended family of adult survivors.

The need to improve responses to historical allegations of child abuse has been a long standing concern of this office. In this context it is worth noting that in response to recommendations in a investigation we conducted in 2010, FACS has recently enhanced the most recent addition of its Mandatory Reporter Guide (MRG)[27] to include information about reporting past abuse of someone who is now an adult as well as advice about the counselling and support services offered by NSW Health's SAS to adult survivors of child sexual abuse.[28]

Our audit identified the need to provide better services and supports for adult survivors of childhood sexual abuse and to carefully examine all historical reports of sexual abuse made by adults for evidence of any current risks to children. With a rise in reports of historical abuse to be expected as a result of the work of the Royal Commission, a commensurate increase in counselling for this group, and support and resources devoted to identifying risk will be critical.

Services for adults in custody

Surveys of Aboriginal men and women[29] in custody have shown that a significant proportion report being sexually assaulted as children.

Breaking the Silence raised concerns about the absence of appropriate services for incarcerated adults who make disclosures of child sexual assault and the absence of an appropriate supportive response when disclosures are made. The ACSAT recommended that Corrective Services 'develop and fund a model to provide child sexual assault counsellors/program coordinators in correctional facilities'.

In NSW, Justice Health[30] is responsible for screening offenders in order to capture any mental or physical health needs and refers patients who have experienced sexual assault to the Local Health District SAS for management. As discussed, adult survivors of child sexual assault are the lowest priority group for the SAS, and as a result, there is a very limited capacity for inmates who have made a disclosure of child sexual assault to receive a service from the SAS.

We noted in our report that in trials by (then) Victims Services of the provision of counselling services to inmates at two correctional centers[31] both counsellors were operating at capacity and had a wait-list for further referrals. A significant proportion of the requests for counselling at that time appeared to relate to sexual assault. We commented in our Audit Report that there would appear to be value in continuing and expanding the trial programs to correctional centers across the state. We also noted that there appeared to be significant scope

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[27] The Mandatory Reporter Guide assists mandatory reporters who have become concerned about possible abuse or neglect of a child or young person and must make a decision about whether or not to report their concerns to the Child Protection Helpline.

[28] *Keep Them Safe Factsheet No. 3b* (http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0006/167154/MRG_enhancements_list.pdf)

[29] *Responding to Child Sexual Assault in Aboriginal Communities*, NSW Ombudsman, December 2012, p. 112.

[30] Now known as Justice & Forensic Mental Health Network, this is a state-wide Board-governed Specialty Network delivering health care to adults and young people in contact with the forensic mental health and criminal justice systems, across community, inpatient and custodial settings.

[31] Dillwynia Correctional Centre and Wellington Correctional Centre.

to improve responses to disclosures of child sexual assault made by inmates and we agreed with Corrective Services' suggestion that 'staff training in sensitive and effective responses to disclosure of sexual assault victimisation as a child could be of assistance'.[32]

Victims of intra-familial sexual assault

Although not within the Commission's remit, it is important in the context of allocation of finite resources to acknowledge the significant proportion of child sexual assaults which occur within an intra-familial context. Accurate estimates of the level and types of abuse are difficult to determine, however there is growing recognition that siblings are responsible for a significant proportion of child sexual abuse and assaults. The New Street Adolescent Service[33] has estimated that half of its cases relate to abuse against a sibling.[34] There is evidence which indicates that an appropriate response to victims and non-offending family members can be critical to ensuring that appropriate protective measures are put in place to prevent further abuse being perpetrated by the offender.

Our audit identified an urgent need for NSW to review its current arrangements for providing therapeutic treatment for children and young people who have problematic and abusive sexual behaviours. Despite the recent expansion of New Street, those who live outside the areas where these specialist programs are currently based have little chance of receiving the help they need.[35] And while Juvenile Justice offers important specialist programs and interventions there are numerous impediments to helping young people with multiple and complex needs within the relatively brief time allowed by a control order or a community supervision plan.[36]

There is a real danger that a small but potentially high-risk group of young people are falling through these gaps, and receiving no effective agency response to their sexually abusive behaviours. As a result, we recommended in our Audit Report that all agencies and services with responsibilities in this area come together to consider creating a cohesive legislative and policy framework that explicitly sets out their respective roles in supporting effective treatment strategies – including the use of treatment orders.37 We also recommended that consideration should be given to adopting elements of the scheme introduced by the Victorian Government in 2007 for identifying and diverting into treatment young people found to be engaging in sexually abusive behaviours,[38] and it is pleasing to note that NSW Health has now recommended that a combined interagency review consider whether a similar model to the Victorian scheme could be established in NSW.[39]

After our audit was finalised, the only service in NSW which provided specialist support for children and families affected by intra-familial sexual assault, the Cedar Cottage program,

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[32] NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.113.
[33] New Street is NSW Health's therapeutic program for responding to children and young people aged 10-17 years who sexually abuse.
[34] Review of NSW Health Counselling Services, Final Report to NSW Department of Health, 11 February 2011, ARTD Consultants, p.71.
[35] Sydney, Newcastle, Tamworth, Dubbo and more recently in the Illawarra and Shoalhaven Local Health District.
[36] See section 16.4 'Juvenile Justice programs to address sexually abusive behaviours', NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 210.
[37] See recommendations 65 – 73. NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 216 - 217.
[38] This scheme is outlined in NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 215 – 216.
[39] Advice provided by NSW Health in implementation monitoring process.

was closed.[40] While this was developed as a diversion program for offenders, the program also provided counselling and support to victims and their non-offending family members in order to protect children and prevent further assault. Funds for the Cedar Cottage program were re-allocated to the New Street Adolescent Service. We recommended that the New Street service be expanded and that modelling around demand be undertaken to guide this process. The modelling has now been completed and NSW Health is developing service standards to support the expansion of New Street and an additional New Street service is being established this year. We also note that the recent Joint Select Committee report on Sentencing of Child Sexual Assault Offenders recommended creating a program to replace Cedar Cottage, for treatment of low risk offenders.[41]

3. Geographic considerations

Our audit found that agencies struggle filling counselling positions in regional and remote areas of NSW. As a result, many victims of child sexual assault in NSW simply do not have access to counselling. There are fewer services available in rural and remote areas relative to the major centres, and fewer services available which provide a culturally appropriate service to Aboriginal clients relative to non-Aboriginal clients.

Recruitment and retention

When *Keep Them Safe* was released in March 2009, it acknowledged that while NSW Health has a broad network of sexual assault services for children and adults, workforce recruitment and retention were 'significant issues' requiring attention in the short term.[42] Difficulties in recruiting and retaining staff were repeatedly identified during our audit consultations as a fundamental barrier to services being able to meet demand, particularly in rural and remote locations. Local Health Districts covering these regions reported the highest vacancy rates and the greatest difficulty filling positions.

Vacancy rates have a major impact on the capacity of an SAS to provide a service to victims. For example, one SAS in Western NSW advised us that their only counsellor position had remained vacant for the duration of the position-holder's previous maternity leave, due to unsuccessful recruitment attempts.

Our Audit Report highlighted the need for a whole-of-government approach to recruiting staff to high needs areas in NSW, noting the discrepancies in the incentives offered to staff by different government agencies and across different employment categories. In our view, a whole-of-government structure for incentives is critical to resolving these issues. We recommended that the Public Service Commission consider the observations made in our Audit Report in developing and implementing a whole-of-government recruitment and retention strategy.

In the absence of such a structure, we recommended that NSW Health review the locations and positions with high vacancy rates and poor staff retention and put in place stronger incentives schemes for these areas.[43]

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[40] Cedar Cottage closed on 19 September 2014 (http://www.wslhd.health.nsw.gov.au/Cedar-Cottage accessed 23/10/15.)
[41] *Every Sentence Tells A Story - Report On Sentencing Of Child Sexual Assault Offenders* Joint Select Committee on Sentencing of Child Sexual Assault Offenders, Report 1/55, October 2014, p.113.
[42] NSW Government, *Keep Them Safe: A shared approach to child wellbeing*, 2009, p.13.
[43] Recommendation 26, NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 115.

In response to our Audit Report, the NSW Government has recommended the development of a new incentive scheme for counsellor, caseworker and other positions in difficult to recruit locations.[44] In addition, the revised *NSW Health Professionals Workforce Plan 2012-2022*[45] was released in September 2015 and aims to increase the number of health professionals working in regional, rural and remote communities, support rural training and improve capacity planning.[46] The *NSW Rural Health Plan* towards 2021[47] released in 2014, also provides a strategic framework to build the rural NSW Health workforce through enhanced recruitment, training, career development and support, including e-Health.

In addition, NSW Health has purchased service enhancements from all rural and regional Local Health Districts to ensure the availability of 24/7 integrated psychosocial, medical and forensic crisis responses for child and adult victims of sexual assault.[48]

Outreach

In NSW, each Local Health District has one or more dedicated SAS response site to provide services across the district. However, a number of the Local Health Districts located in rural and regional NSW advised us that they do not consistently have the capacity to provide an outreach service to towns which are located furthest away from the site.

The primary barriers to providing outreach were the additional travel time required, as well as the high local demand for services. In addition, one Local Health District identified difficulties in accessing appropriate, child friendly rooms in outlying areas, which made it problematic to promote and establish an outreach service, and to operate a drop-in service.

The large geographical distances that need to be covered in Western NSW were identified as the primary barrier to providing effective outreach services, both for the SAS and for other service providers. Combined with limited transport options to enable the client to travel to the service, the result in many instances is that there is little or no access to counselling services for victims of sexual assault living in these parts of NSW. In response to our Audit Report several Local Health Districts in rural areas have received funds specifically for flights and vehicle costs to retrieve victims and transport medical and counselling staff.[49]

However, in some communities this service gap has existed for many years and consequently there is little knowledge of the SAS. As a result, developing the capacity of the SAS in these communities not only requires the resources for a counsellor to provide direct services to victims, but also the resources to build relationships so victims feel comfortable using the service. (We discuss the issue of capacity under 'Service systems issues' below.)

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[44] Advice provided by NSW Health in implementation monitoring process.
[45] http://www.health.nsw.gov.au/workforce/hpwp/pages/default.aspx
[46] Advice provided by NSW Health in implementation monitoring process.
[47] http://www.health.nsw.gov.au/rural/Publications/rural-health-plan.pdf
[48]NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, June 2015, p.13,14.
[49] NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, June 2015, pp13,14.

4. Service systems issues

In addition to the overall capacity challenges faced by services, our review also identified a range of organisational and structural issues relating to the effectiveness of counselling referral pathways; how different services work together; and the flexibility of services. Our audit also identified a number of significant gaps in the provision of sexual assault services around the state. This included inconsistent availability of outreach services, a lack of services available for adult survivors of child sexual assault, limited specialist services for victims of intra-familial sexual assault and a lack of services for prison inmates (See 'Diverse victims and survivors' above).

These problems were exacerbated by the very limited capacity of the NSW Health SAS, as the largest provider of sexual assault counselling, to monitor the demand for their services or the extent to which their services were meeting this demand, due to significant shortcomings in their data collection processes. In our Audit Report we made recommendations in relation to specific data which needed to be collected from SASs to begin to address this issue.[50] In response (then) NSW Kids and Families, on behalf of NSW Health, undertook an SAS 'data build' project to capture service demand. A minimum data set and report specifications have been developed to address the requirements in our Audit Report. We have also been advised that state-wide implementation of the database was due to commence in the second half of 2015.[51] Again it is unclear whether and to what extent the dissolution of NSW Kids and Families will impact on this project.

Need for discretionary funds for SASs

In addition to the overall budget constraints of the SAS, our consultations identified that some services experienced difficulties in delivering a quality service due to a lack of flexibility in managing their budget, and a lack of discretionary funds for expenses other than staffing.

In some parts of the state, we were advised that issues with vehicle availability, combined with an absence of brokerage funds to facilitate alternative transport for clients, resulted in appointments being cancelled due to the inability of counsellors to travel to victims within their outreach area, or vice versa. Counsellors also told us of having to buy incidental items out of their own pocket as a result of not having access to any discretionary funds. Many SASs did not have a protected goods and services budget, and reported 'having small or insufficient funds available to cover expenses such as office items and staff training'.[52]

It was apparent that individual services needed to have access to flexible funds in order to meet client needs in relation to counselling. While these expenses are not frequent or substantial, having access to brokerage funds for emergency accommodation, local transport, or other services or incidental costs, would significantly improve the capacity of the SAS to provide flexible services to victims.

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[50] See recommendation 23, NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 114.

[51] Response provided by the former Minister for Family and Community Services, Hon. Pru Goward, 20 December 2013.

[52] *Review of NSW Health Counselling Services: Child Protection Counselling Services, Sexual Assault Services, Child Protection Units, Domestic and Family Violence Services Mapping, Final Report to NSW Department of Health,* February 2011, ARTD Consultants, p.47

In our Audit Report we recommended that NSW Health consider allocating additional funds to Local Health Districts to provide SASs with access to a pool of flexible funds for brokerage and other incidentals.[53] We have been advised that one-off and recurrent funds have been provided to allow rural and regional Local Health districts to implement locally responsive service models involving a range of initiatives. For several Local Health Districts this has involved funds specifically for flights and vehicle costs to retrieve victims and transport medical and counselling staff.[54]

Improving the coordination and provision of state-wide counselling services

As we noted at the outset, there are a range of providers who deliver counselling services to victims of child sexual assault in different parts of the state, with different referral pathways, eligibility criteria and service options. The transfer of funding responsibility for CASAC services from FACS to NSW Health does represent some streamlining of arrangements. However, it appears that eligibility criteria still varies among services. The counselling landscape also includes the NSW Health Senior Health Clinicians in JIRT. These positions play an important role in referring children and their non-offending family members to appropriate counselling – although they generally do not provide a direct counselling service.

The involvement of multiple service types and JIRT makes for a confusing system that vulnerable victims have to navigate. It is also complex and at times, inefficient for frontline workers.

In areas where there are multiple child sexual assault counselling providers to choose from, our consultations revealed that victims are not always referred to a service which is the most suitable for their needs, or are frequently referred to a service which does not have the capacity to respond quickly. We were advised by counselling providers that if a service cannot be provided in these circumstances, the child or their family will be given the contact details of nearby services which may be able to assist them. Given that most services are operating beyond capacity, this can lead to victims having to make contact with several services before they are able to find support.

Similar issues applied to cases handled by the JIRT, where the JIRT Senior Health Clinician makes the counselling referral for the child. The establishment of the 25 Senior Health Clinician positions in 2009 was an important investment by Health in the JIRT program. However, against a background of significant capacity challenges in the counselling sector, our Audit Report highlighted the need for a review of the JIRT's resources including an examination of Health's resourcing requirements to enable it to adequately fulfill its JIRT responsibilities. The decision by NSW Health to fund additional Senior Health Clinical positions will provide a significant boost to the capacity of JIRT to respond to the needs of victims and survivors who have made formal reports of abuse.

In addition, our examination of JIRT found an absence of basic performance indicators to measure, for example, the number of children and their non-offending parents/carers referred

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[53] Recommendation 24c), NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.114-115.

[54] NSW Government, *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, June 2015, pp13,14.

to counselling and the acceptance rate.[55] We recommended the review of JIRT also focus on establishing a solid framework for better ongoing monitoring of JIRT's performance.[56]

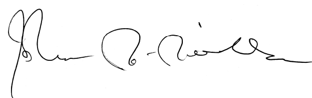
Our consultations also identified that there was little knowledge sharing between local providers across the sexual assault counselling sector as to how they could work more collaboratively to meet service gaps and build a quality Aboriginal counselling workforce. We formed the view that service providers at a local level needed mechanisms in place for communicating with each other about the types of clients they can assist, as well as their capacity at any one time. Ideally, this would also involve arrangements between services for 'facilitated referrals' to shift the onus away from the victim and onto the service provider to secure an appropriate referral. Counselling services in high-need locations should be sufficiently 'joined-up' so that victims and workers are able to use a single referral process or inter-face to identify the most appropriate counselling provider.

In our view, it is essential for Government to obtain a clear understanding of the overall capacity challenges facing the sexual assault counselling sector – including the ability of children to access services across the state – before it can make informed decisions on addressing the long-standing inability of the sector to meet demand. For this reason, we recommended that central agencies – NSW Health, FACS and the (then) Department of Attorney-General and Justice – jointly review the capacity of the child sexual assault counselling services and identify how they can be better integrated. We also recommended the review consider developing a single referral pathway especially in areas with serious capacity issues.[57]

In 2011, NSW Health conducted a review of counselling services which similarly concluded that integration of counselling services within NSW Health would improve policy and strategic guidance, and visibility. We have also been advised that in response to our recommendations NSW Health is undertaking a review of the sexual assault, domestic violence and child protection procedures. This will include the development of minimum standards and clinical guidelines that address joint working arrangements across health services, information sharing and referral pathways to ensure better integration and coordination of all health psycho-social and counselling services. NSW Health and FACS have also indicated support for the scoping of a further joint agency project to consider whether sexual assault counselling services can be better integrated across government.[58]

If you require further information, please do not hesitate to contact Ms Julianna Demetrius, Assistant Ombudsman (Strategic Projects) on 9286 0920.

Yours sincerely



Professor John McMillan
Acting Ombudsman

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner

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[55] NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p.92.
[56] Recommendation 20(b), NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 99-100.
[57] Recommendation 25, NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities*, December 2012, p. 115.
[58] Advice provided by NSW Health in implementation monitoring process.