AMSANT Response to Sexual Violence Prevention and Response Framework discussion paper

August 2019

Introduction

AMSANT is the peak body for the community controlled Aboriginal primary health care (PHC) sector in the Northern Territory (NT). AMSANT has been established for 25 years and has a major policy and advocacy role at the NT and national levels. We have 26 members providing Aboriginal comprehensive primary health care across the NT from Darwin to the most remote regions.

The ACCHSs sector in the NT is comparatively more significant than in other jurisdictions, being the largest provider of Aboriginal primary health care services to Aboriginal people in the NT. Around two thirds of all Aboriginal PHC services in the NT are provided by ACCHSs.

AMSANT welcomes the opportunity to provide comment on the Territory Families discussion paper for an NT sexual violence prevention and response framework. After reviewing the discussion paper we feel there are two fundamental principles which require significantly more emphasis within this framework, discussed in more detail below:

- Understanding and responding to trauma
- Supporting Aboriginal leadership, control and culture

The remainder of this submission focuses on our identified priorities for action areas 1, 2 and 5 from the discussion paper.

Understanding and responding to trauma

Given the disproportionate impact of sexual violence on Indigenous people in Australia, who are 3.4 times as likely to be the victim of sexual assault as non-Indigenous Australians (AIHW 2018), we consider it a significant omission that the discussion paper contains no mention of the ongoing impacts of colonisation or experiences of discrimination for Aboriginal people.

We reiterate the position of the Healing Foundation 2017, that an effective strategy to prevent and reduce and respond to sexual violence in Aboriginal communities must be based in truth, recognising the impacts of: founding violence, structural violence and cultural breakdown, intergenerational trauma, disempowerment and alcohol and other drugs.

Health and wellbeing for Aboriginal people is often understood to encompass domains of connection to culture, body, mind and emotions, land, family and kinship, spirituality and community (Gee et al. 2014). Processes of colonisation and structural discrimination have caused disruptions to these connections for many people, with serious implications for an individual's sense of self and identity, including for the way that people understand their sexuality and gender roles.

AMSANT understands Culturally Responsive Trauma Informed Care (CRTIC) to be an approach of best practice that can act to safeguard from further systemic and individual traumatisation. Evidence suggests that, with time and resources put towards embedding CRTIC into all aspects of service delivery including organisational policies, systems and practices, efficiency and effectiveness will be enhanced resulting in better health outcomes long term (Atkinson 2013; Browne et al. 2016).

There are vast differences between Aboriginal community's belief systems, their languages and historical experiences of colonisation. As such, a generic and mainstream model of trauma informed care would be unsuitable and potentially harmful in its delivery to rural and remote communities. By implementing CRTIC the approach becomes contextually tailored and localised to the nuances of each place, thus determining the outcome of equality (Browne et al. 2016).

Recommendation 1: That all NT Government services and systems engaging with people who have experienced sexual violence adopt an approach of culturally responsive trauma informed care.

Within the context of the NT, we feel it is necessary to emphasise that policies and practices which contribute to the stereotyping of entire groups of people as 'offenders' causes harm and is counterproductive to the prevention and rehabilitation of sexual violence. A pertinent example of this from our recent history was seen during the NT Intervention, where Aboriginal men where indiscriminately cast as perpetrators of child sexual abuse, with devastating and ongoing effects.

Rather than approaches which seek to demonise or isolate sections of our community, AMSANT advocates for increased support of community-led healing programs. The Canadian Community Holistic Circle Healing Program, for example, has demonstrated improved outcomes including reduced

recidivism when working with communities with alarmingly high rates of child sexual abuse - 75% of people in the community of Hollow Waters (Ross 1995).

Similar programs for youth and adults have been run in the Northern Territory. We note, for example, the work of Lukas Williams of Ganna healing, who runs healing circles in the NT which aim to create safe spaces for men to talk about complex issues, including violence, in their communities.

Recommendation 2: That the framework include increased support for community-led healing programs based on Aboriginal knowledge.

Supporting Indigenous leadership, control and culture

Given the disproportionate impact of sexual violence on Aboriginal people in the NT, it is essential that this framework both supports Aboriginal organisations to provide prevention and support services, as well as ensuring that there is a strong role for Aboriginal leaders in the oversight of the framework's implementation. Ensuring that this framework is relevant and its implementation is effective and culturally safe will require the involvement of Aboriginal people and their organisations, starting from development and consultation, all the way through to monitoring and evaluation.

Directing expenditure through Aboriginal organisations will ensure that investment will deliver the best outcomes for Aboriginal people. In recent years we have seen increasing amounts of Aboriginal specific funding, and funding for programs delivered to Aboriginal people, provided to mainstream, non-Aboriginal service providers which has undermined the effectiveness of overall expenditure.

We know that competitive grants funding does not work for Aboriginal service delivery. In fact, it is our experience that increased competition usually leads to suboptimal outcomes by; undermining the effectiveness of individual services; reducing service integration and increasing fragmentation; and weakening existing relationships and knowledge.

In the health sector, the Aboriginal community controlled model of delivering comprehensive primary health care provides a number of significant additional benefits that are not provided through government, not-for-profit and private sector providers including greater cultural safety. These benefits considerably add to the cost effectiveness of investment in ACCHSs, both in terms of the quality of service provision as well as in relation to broader health and health-related outcomes.

Recommendation 3: That the framework incorporates oversight processes that include Aboriginal leaders and organisations, and supports increased Aboriginal control of service delivery.

Recommendation 4: That a 'listening and hearing' workshop for Aboriginal organisations be held as part of the consultation process for the development of this Strategy, including financial support for organisations from remote areas to attend.

Action Area 1: Preventing Sexual Violence

Addressing underlying determinants and improving outcomes for vulnerable and disadvantaged children and families will be fundamental to the prevention of sexual violence in our communities. In particular, research demonstrates links between youth who suffer abuse and neglect in early life, including as victims of sexual abuse themselves, and future sexual offending (Righthand and Welch 2005; Papalia et al 2018).

There is no single cause of child abuse and neglect. The harms that children incur result from a mixture of complex dynamics that exist at and between the level of the individual, family, community and society. As noted above, in the context of Aboriginal children and families, some of the most complex health, mental health, substance use, justice and child protection issues can best be understood in the context of historical and transgenerational trauma.

AMSANT advocates for the adoption of a public health approach to tackling sexual violence, under which the weight of investment should shift from the high cost statutory and tertiary end of the system to the preventative measures of primary and secondary interventions, particularly those leading to ongoing cost reductions over time.

However, we acknowledge that while some of these interventions may have immediate impacts, others will have generational effects as children with stronger supports are better able to parent themselves. Investment in tertiary and crisis services will continue to be required, however, the amount of investment required will decrease as prevention policies start working.

The NT Aboriginal Health Forum (NTAHF) has developed an agreed framework of core services that sets out a comprehensive, public health approach for improving outcomes for Aboriginal children up to age 5. This document, *Progress and Possibilities: What Are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT?*, sets out the core services required to improve childhood outcomes.

The model breaks services down into three levels: universal (available and accessible to the whole population), targeted (available to 'at risk' groups or individuals), and indicated (for individuals or families with an established condition or problem). It outlines the need for an integrated system that provides trauma informed and culturally responsive services across the following key categories:

- Pre-pregnancy care
- Quality antenatal and postnatal care
- Nurse home visiting
- Clinical child health care
- Quality early learning
- Parenting programs
- Nutrition
- Supporting vulnerable families
- Supporting children with physical problems and developmental delay
- Public health policy and social determinants

The health component outlined in Progress and Possibilities is provided in a reasonably consistent way across the sector, although a recent survey of AMSANT member services found that nearly all said that they were under resourced to provide child health services, particularly to the under-five age group which is a critical period.

Other components such as family support, early childhood education and support for children with disabilities and developmental delay are provided in a much more inconsistent and haphazard fashion, largely because they are subject to competitive tendering.

Recommendation 5: That NT Government increase investment in prevention and early intervention to ensure the universal delivery of services as set out in the NTAHF document Progress and Possibilities.

In addition, we note that there is a lack of preventative and community education programs about child sexual abuse and inappropriate sexual behaviour. Furthermore, the legislation on sexual activity in young people and children classifies a 17 year old having a consensual relationship with a 15 year old as being potentially abusive and subject to mandatory reporting by clinicians under the Care and Protection Act.

Prevention strategies should be funded both at individual child and community levels to address this, including education on appropriate sexual behaviour for young people and community as well as

tertiary services for children and young people with significantly aberrant behaviour. Young people and adults must know what the legislation says about sexual activity in young people less than sixteen so they do not unknowingly break the law.

Congress' Community Health Education Program (CCHEP) has been delivering holistic sexual health education to young Indigenous women living in and around Central Australia since 1998 and to young males since 2011. The CCHEP program provides awareness and basic holistic sexual health education to young people in our local schools, and incorporates educator training to enable community-based workers, such as Aboriginal health practitioners and teachers, to confidently deliver the program to their own target groups. This is an example of the kind of community based education which should be supported by the NT Government under this framework.

Recommendation 6: Ensure access to age-appropriate community education on appropriate sexual behaviour and the law in relation to sexual activity in children.

Action Area 2: Responding to children and young people who have experienced sexual violence

There is currently a significant lack of counselling services for children who have been a victim of sexual abuse, particularly in remote communities, although even services in regional towns and centres are limited. Children can be evacuated from remote communities for initial medical treatment and assessment at the Sexual Assault Referral Centre (SARC) in Darwin, Katherine, Tennant Creek or Alice Springs.

However, while SARC is able to provide ongoing counselling services in these towns, they are not funded to provide ongoing services to children who return to remote communities. This means that children are sent back to their communities without ongoing follow up. This kind of outreach was available as a program called Mobile Outreach Service Plus (MOS Plus), between 2008 and 2016.

Funding for this program was cut by a joint decision from the Commonwealth and NT governments with no consultation with communities or service providers. Instead, services were asked to refer children to the Child and Adolescent Mental Health Service (NTG mental health service) which had also recently ceased to provide outreach to some remote communities whilst other communities never had any services in the first place.

MOS Plus had some major flaws – it was a vertical government provided program which expanded too quickly due to pressure in the NT Emergency Response context, resulting in services lacking in cultural safety and effectiveness as a result of a flawed model. Regardless, the lack of consultation with service providers and communities about ceasing this sensitive and important program with no effective alternatives is symptomatic of how governments at times fail to respond to the needs of vulnerable children and families and communities.

There is a growing SEWB workforce in remote communities which could be supported through a hub and spoke service delivery model so that specialist input could be provided by agencies such as SARC but with some ongoing follow up provided by local ACCHSs or government primary health care – noting that it will be crucial that the service is provided by a counsellor of the right gender.

Services available to young people in the juvenile justice system are improving slowly but there are still key gaps, noting in particular the lack of rehabilitation and therapeutic programs for young people who have committed sexual offences.

Recommendation 7: That services be made available for victims of sexual abuse and children displaying inappropriate sexual behaviours or who have committed sexual offences, including as outreach to remote communities.

AMSANT would also like to note our concerns about the operation of laws which currently act to criminalise consensual sex between young people where there is a two year age gap and which requires health professionals to report this to child protection and/or the police.

Health practitioners within AMSANT's member services have expressed concern about the impact of these laws in deterring young people from seeking health care or not disclosing the true nature of their relationship, in some instances where they are concerned that they, or their partner may be criminalised. An AMSANT member survey conducted five years ago found that the majority of member services wanted this rule to change.

It is AMSANT's position that the focus for health professionals practicing in the NT should be on assessing the health of any given relationship between young people, including on key aspects such as equality, coercion and consent, rather than being required to make a mandatory report based merely on the age gap.

Recommendation 8. That the NT Government review the provision requiring health professionals to report relationships in children aged 14-16 when their partner is two years older than them.

Action Area 3: Strengthening systems that respond to sexual violence

Anonymous Children's Helpline

The establishment of an anonymous, 24 hour children's helpline would help to address barriers faced by children and young people in reporting sexual violence and assault by providing easy to access, confidential advice and support. Barriers to reporting sexual violence, particularly for children and young people include:

- Fear of the consequences of reporting – violence from family or community members or being ostracised from community
- Fear of being removed – exacerbated by the past history of interaction with powerful authorities (Territory Families and Police) and the history of Stolen Generations
- Fear about the perpetrator going to jail and implications of this in terms of community repercussions (memory of deaths in custody)
- Fear of not being believed
- Lack of understanding about what constitutes 'sexual abuse'

Similar helplines are well-established worldwide, especially throughout Europe, and they have been found to provide a reliable means of reporting accurately on sexual violence, supporting victims with counselling and referral, and calling attention to gaps in child protection systems.

In 2009 over 11.5 million phone calls were made to children's helplines in Europe, representing 91% of contacts by children seeking counselling, with the other 9% made up of in-person, outreach and web-based counselling (Noz M n.d).

Recommendation 9: That the NT Government establish an anonymous, 24 hour children's helpline

Barnahus (Children's House) Model

Disclosure of sexual assault by children is challenging enough within current systems, and often those children who do choose to disclose are re-traumatised by the investigative processes and court procedures, which are not child-centred. Our current system does not achieve the best results for the child, the community or the criminal justice system.

The needs of children in sexual assault matters are totally different from those of adults in the same situation. A multi-disciplinary, child-centred approach is required, which places the health and wellbeing of children and young people at the centre.

The Barnahus ('Children's House') model, was first established in Iceland in 1998, and has been implemented throughout Europe – in Sweden, Norway, Greenland, Denmark and Croatia. It is also currently being adapted in the UK to accommodate an adversarial common law system. Parkville Children and Youth Centre in Perth is also currently developing a model for the implementation of this model in Western Australia.

In Iceland, Children and young people are referred to the Barnahus by child protection services, medical practitioners or other concerned people, when they exhibit some symptom suggestive of sexual abuse. Children and young people can also self-refer. At the centre, children can:

- Be interviewed and medically examined for forensic purposes;
- Be comprehensively assessed;
- Receive relevant therapeutic services from appropriate professionals – family counselling, therapy and support.

This model addresses barriers to reporting by providing a child-friendly space where children and young people can be supported to make a disclosure, and can receive all the services that they need under one roof (noting that remote children will require some ongoing contact which could be undertaken via skype or other telehealth technology), therefore providing tertiary intervention for those who have been sexually abused, to lessen its impact upon them and facilitate a return to a positive situation.

Recommendation 10: That Territory Families consider adopting an adapted Barnahaus (Children's House) Model to ensure that children who have experienced sexual assault are not re-traumatized by our legal systems

References

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