Board of Inquiry into historical child sexual abuse in Beaumaris Primary School and certain other government schools

TRANSCRIPT OF PROCEEDINGS

BOARD OF INQUIRY INTO HISTORICAL CHILD SEXUAL ABUSE IN BEAUMARIS PRIMARY SCHOOL AND CERTAIN OTHER GOVERNMENT SCHOOLS

PUBLIC HEARING
MELBOURNE

THURSDAY, 23 NOVEMBER 2023
AT 10AM

HEARING DAY 6 (PUBLIC VERSION)

APPEARANCES

MS F. RYAN SC – COUNSEL ASSISTING
MS K. STOWELL – COUNSEL ASSISTING

<THE HEARING RESUMED AT 10.02 AM

CHAIRPERSON: Good morning, everyone. The Board of Inquiry has been advised of and is aware of a media report about the death of Darrell Ray. We understand that his death will be significant to a number of people who have been involved with this Board of Inquiry and that this may be a distressing development for them. We understand this impact and our thoughts are with all of those in the community who are affected by this news.

Before we begin today, I want to remind everyone that the restricted publication orders made by the Board of Inquiry during previous hearings will continue to apply. Yes, Ms Ryan.

MS RYAN: Thank you, Chair. I will now provide an introduction to phase 3 of our public hearings. The Board of Inquiry's Terms of Reference require it to inquire into and report on whether there are effective support services for victim-survivors of historical child sexual abuse in government schools, having regard to other inquiries and reforms that have taken place since the child sexual abuse occurred, being since the 1960s, '70s and the relevant period, appropriate ways to support healing for affected victim-survivors, secondary victims and affected communities, including, for example, the form of a formal apology, memorialisation or other activities.

Further, one of the objectives of the Board of Inquiry is to develop a shared understanding among all Victorians of the impact of child sexual abuse on victim-survivors, secondary victims, affected communities and society.

The Board of Inquiry has spoken to victim-survivors, secondary victims and affected community members in private sessions to understand the impact that the abuse has had on their lives and their experiences seeking support. The inquiry has listened to these victim-survivors, secondary victims and affected community members about what is needed to support healing. The Board of Inquiry has also engaged with a number of experts in relation to child sexual abuse, its impact on a person's life journey and best practice responses to support healing and recovery. We will continue to hear from experts over the next two days.

Public hearings are part of the Board of Inquiry's information gathering phase and we will hear more information over the course of the next two days. The Board of Inquiry is yet to form a position on what constitutes effective support services or appropriate ways to support healing.

Today, we will hear from a panel of Victorian government representatives to learn more about current government-funded and delivered support services. Chair, following this phase of hearings, the Board of Inquiry will also be conducting a series of round tables with representatives from the service sector, other stakeholders and victim-survivors and secondary victims to further examine the

Terms of Reference relating to support services and healing and explore the key themes and issues that are raised over the next two days.

I now turn to the prevalence and impacts of child sexual abuse. The Australian childhood maltreatment study, ACMS, is a landmark study measuring the five major types of childhood maltreatment in Australia: physical abuse, sexual abuse, emotional abuse, neglect and exposure to domestic violence. The ACMS is the first nationally representative study like this conducted in Australia. Over 8,500 Australians aged 16 years or over participated in the study. It is one of the most comprehensive studies on these issues ever conducted globally.

Analysis of ACMS data is still ongoing. Importantly, the ACMS has not just examined prevalence. It also examined the impacts of child maltreatment, including child sexual abuse. Primary findings were published in early 2023. The ACMS provided us with critical understanding of the impacts of child sexual abuse in Australia, and provides a benchmark dataset that will allow us to estimate prevalence over time, responding to evidence gaps identified by the Royal Commission into Institutional Responses to Child Sexual Abuse.

Relevantly, the ACMS found childhood sexual abuse is widespread. 28 and a half per cent of Australians aged 16 years or over have experienced child sexual abuse. Relevant to victim-survivors within the scope of our inquiry, this includes 30.7 per cent of people between ages 55 to 64 and 27.4 per cent of people aged 65 years or older. These figures include people who experienced child sexual abuse in an institutional setting such as a school, but do not just relate to institutional abuse. They include abuse within the broader community.

Childhood sexual abuse is rarely an isolated incident. 78 per cent of respondents who experienced child sexual abuse reported that it happened more than once. Childhood sexual abuse has a range of profound impacts on a victim-survivor's mental health and is also associated with an increased risk of mental health disorders, post-traumatic stress disorder, generalised anxiety disorder, alcohol use disorder and major depressive disorder.

Australians who experience child sexual abuse are 2.7 times more likely to have self-harmed in the prior 12 months, 2.3 times more likely to have attempted suicide in the prior 12 months and two times more likely to be cannabis-dependent. The impacts of child sexual abuse are long lasting and remain well into adulthood, and the study noted that harmful behaviours and conditions persist well beyond the experiences of maltreatment.

Research, including a review drawing upon evidence commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse and expert witness statements considered the broader impacts of institutional child sexual abuse specifically. These include victim-survivors can experience a deep sense of institutional betrayal, particularly in cases where victim-survivors perceive that the institution has been complicit or has concealed the abuse.

Victim-survivors of institutional child sexual abuse can experience a range of adverse mental health impacts which can persist later in life, including, as I outlined previously, post-traumatic stress disorder, depression, anxiety, personality disorder, suicidality and self-harm, obsessive compulsive disorder and mood disorders. These findings are in line with the ACMS.

Victim-survivors of institutional child sexual abuse report a range of physical health problems which can be pervasive and ongoing. Victim-survivors' ability to maintain and develop healthy relationships can be greatly impacted. Feelings of shame, guilt and self-blame, combined with reduced ability to trust and profound anger can compromise their relationships and exist as ongoing barriers between themselves and others.

Victim-survivors' education and employment can be negatively impacted. Educational disengagement and disadvantage associated with institutional child sexual abuse may be associated with flow-on effects, including underemployment or unemployment, higher rates of antisocial or criminal activity, homelessness and housing problems.

The inquiry has also heard that the impacts of child sexual abuse on educational outcomes can be particularly marked in cases where the abuse occurred in a school setting, because school and learning are no longer considered safe.

Impacts on secondary victims are profound. Research has confirmed that child sexual abuse in an institutional setting results in vicarious trauma for victim-survivors' families and communities.

The Royal Commission into Institutional Responses to Child Sexual Abuse appointed the Australian Institute of Family Studies to explore the effects of child sexual abuse on secondary victims. The Australian Institute of Family Studies conducted 50 interviews with victim-survivors of institutional child sexual abuse and their family members, being partners, parents, children and siblings. Secondary victims can experience challenges before a victim-survivor discloses their experiences of the abuse which can relate to a victim-survivor's emotional withdrawal, mental health challenges and/or risk taking and impulsive behaviour.

Secondary victims can also take on a support role for victim-survivors, including providing support with mental health and drug and alcohol challenges and engaging with criminal and civil justice systems. Secondary survivors can experience similar negative impacts of abuse as the victim-survivors, and all participants in the Australian Institute of Family Studies study describe that child sexual abuse had negatively affected their mental and physical health, levels of tension and conflict in the family, long-term relationships within the family, marriage and partnerships and social connectedness.

The ripple effects of child sexual abuse can impact whole communities and the Royal Commission into Institutional Responses to Child Sexual Abuse highlighted how community connectedness can be shattered by the revelation of child sexual abuse, especially when the perpetrator is well liked or the institution is respected or trusted. Chair, the inquiry understands that research in this area is still emerging.

Victim-survivors' service needs. Victim-survivors have a range of service needs. They may need support from different types of services throughout their lives to manage the broad and long-lasting impacts of child sexual abuse. This includes therapeutic support such as counselling, as well as nontherapeutic and more practical support such as financial assistance.

Victim-survivors may also need a range of different types of support concurrently. For example, victim-survivors may have co-occurring alcohol and drug dependence issues as well as mental health needs. Service needs can also change over time in that victim-survivors may need particular support at triggering or critical life points. These life events could include the birth of a child or a child starting school or the death of a relative.

Secondary victims also require support, and research suggests that secondary victims require similar types of support as victim-survivors. Research also suggests that secondary victims require some unique support services including supports to alleviate isolation and encourage open discussion, and access to advice, support and advocacy in order to support the victim-survivor.

Research suggests that victim-survivors are over-represented as service users, and the ACMS has highlighted that victim-survivors of childhood maltreatment, including child sexual abuse, are more likely to have had an overnight hospital admission during the past 12 months and more likely to report a mental disorder for the reason for the hospitalisation, made six or more visits to a general practitioner or Allied Health professional and consulted with a psychiatrist, psychologist, mental health nurse or medical specialist.

The service system involves a number of different types of service settings, types of supports and funding arrangements. The Royal Commission into Institutional Responses to Child Sexual Abuse stated that the existing service system for victim-survivors of institutional child sexual abuse comprises, and I'm quoting:

> "A tangle of participants, professional, service settings and government arrangements across various government portfolios."

Advocacy support and therapeutic services are provided by a range of different types of providers, including mainstream services from GPs, mental health services, alcohol and drug services and housing services, to community-based organisations including services for specific communities or populations, for victims of crime services including the victims assistance program, and specialist

sexual assault support services including Victoria's Centres Against Sexual Assault known as CASA.

The government panel who we will hear from after the break with representatives from the Department of Families, Fairness and Housing, referred to as DFFH, Department of Justice and Community Safety, DJCS, and the Department of Education will give evidence providing further detail about support services for victim-survivors of historical child sexual abuse that are funded or delivered by these departments.

I turn now to the lived experience of victim-survivors relevant to the support service issue. As we explained in the first two phases of our public hearings, the Board of Inquiry has received submissions from and conducted a number of private sessions with victim-survivors, their families and friends, as well as members of affected communities. And they told the Board about their experiences of child sexual abuse, its impacts and their experiences with support services and healing.

Many of the people who made those submissions or attended these sessions wish to do so anonymously or confidentially so that their identity was not revealed publicly. As with other summaries throughout this public hearing, the following summary describes what they told us, but if someone has asked for confidentiality we have not referred to what they told us.

When discussing support services and pathways to healing, victim-survivors and their loved ones have made it clear that one size does not fit all when it comes to addressing the trauma of child sexual abuse. We have also been told that the path to healing is an individual journey and that:

> "What is healing to one is re-traumatising to another."

As covered in earlier hearings, victim-survivors and their loved ones experience a range of consequences from the abuse. These can be both physical and psychological. They can include feelings of guilt, shame or aggression. Sometimes victim-survivors experience these feelings soon after the abuse. Sometimes they can be delayed for many months or even years. These impacts can be wide-ranging, shaping the daily lives of victim-survivors and those around them.

Experiences of abuse can lead to alcohol and drug use, difficulties forming and maintaining relationships, mental ill-health, and cause victim-survivors to struggle with employment and education. The needs of victim-survivors and their loved ones can be significant and varied. We heard a range of experiences and opinions about the availability and utility of support services for victim-survivors of child sexual abuse and the secondary victim-survivors who support them.

A common theme we heard from victim-survivors and their supporters was that it was challenging and overwhelming to understand and engage with support

services. Sometimes this placed pressure on families, friends and communities to effectively fill the gap. Tim Courtney said:

> "I have always felt like there were not enough formal systems in place to help me and other survivors obtain support. I relied on my family and my networks to help me find and build my support network. My experience is that there is still a gulf between places recognising that you have been abused and places that help you address that abuse."

By way of example, Tim told the Board of Inquiry that he could not have accessed the Victims of Crime Assistance Tribunal without the assistance of his lawyers, saying that when he first found out about the tribunal:

> "It was too overwhelming, too complex and too poorly explained for me to navigate it by myself."

Others expressed concern that there is insufficient understanding of the complexities of post-traumatic stress disorder suffered by some victim-survivors of child sexual abuse. Tim told us that a single unified port of call was needed. He said:

> "I believe that victim-survivors of child sexual abuse would be immensely assisted by the introduction of a one-stop shop which a victim-survivor can contact to report their abuse. The organisation can then triage their various needs, advocate for their rights and provide the necessary advice and referrals to guide them through the process of seeking mental health support, social networks, redress and recognition. I often receive calls from people asking me to recommend a service which can support them as a survivor of child sexual abuse, and I find that I do not know of a single entity I can suggest that they contact to cover off on their needs or at least refer them in the right direction."

A common theme was the lengthy waiting times associated with services for victim-survivors of abuse. Several told us it can be hard to get an appointment with a psychiatrist, with waiting lists often being months long. Others reported that there were fewer and fewer specialists available to address the specific trauma suffered by victim-survivors of child sexual abuse. Some reported that treatments were often unaffordable and thought that government assistance with costs was needed to help victim-survivors access these services. Some have been able to access support through Medicare.

Many victim-survivors and their supporters shared with us their experiences of counselling, therapy and other psychological services to address their trauma. We were glad to hear that some victim-survivors have benefitted from access to counselling and therapy services. Others had not always had positive experiences of counselling. One victim-survivor reported being made to feel as if - as though they might have been in the wrong, while another reported that traditional therapy

alienated them from their parents. Some found it difficult to open up and tell their story to people they didn't know or trust. Sometimes it took time to find the right psychologist or counsellor or style of therapy.

Another common theme in the accounts we received was that not all available support services suited all victim-survivors. Sometimes victim-survivors have found that less conventional services have better met their needs. We were told services such as meditation, ice baths, survivor groups and other activities had assisted some victim-survivors in addressing their trauma. Hank told us that he has benefitted greatly from transcendental meditation and a 12-step program, saying:

> "I had to go on a long and hard road before I found meditation and that 12-step program, and I think the reason it took so long was because there is not a good understanding of trauma in government, in the legal profession and in the community. It felt like lots of places that I went to for help couldn't properly understand the impacts of trauma."

Hank thinks that conventional approaches don't work for the kind of trauma suffered by victim-survivors of child sexual abuse and that dedicated services are required for this cohort.

We have heard from secondary victims who have worked to support their loved ones as they deal with the impacts of their abuse. Family, friends and communities often act not just as supporters but as advocates and community organisers for those who've suffered child sexual abuse. Family and friends sometimes suffer their own traumas that they then seek to deal with, with addiction, mental health and suicide.

We acknowledge that these secondary experiences can be challenging and may contribute to intergenerational trauma within families. One secondary victim-survivor close to the Beaumaris community of victim-survivors told us how she's often leaned on and feels like she's drowning as a result. Another secondary victim reported her experience as follows:

> "I'd never thought about how my partner's experiences might have affected me and whether I could benefit from some support services until I was asked about it. Now, I understand why people talk about the ripple effect. I don't know of any support services that are specifically directed at helping those people that are close to victim-survivors who might be providing support themselves."

Tim Courtney also expressed concern that support services are made available to secondary victim-survivors, saying:

> "Access to support services must also be improved for secondary victim-survivors such as friends and family members of victim-survivors who may themselves be exposed to post-traumatic stress disorder and other

> impacts of abuse. There should be a way for families to access support as early as possible to prevent the impacts of abuse from becoming intergenerational."

One secondary victim-survivor told us:

> "I also feel for the community around Beaumaris Primary School. I hope there is support for them too and that they can be involved in the healing process."

Some victim-survivors told us how they only began accessing support services many years after the abuse. Tim Courtney told us that early intervention was important because:

> "Delays can make victim-survivors increasingly socially isolated."

He supports mechanisms such as mandatory reporting and other independent reporting mechanisms to support interventions occur. Other victim-survivors also emphasised the importance of supports like counselling soon after abuse occurred. One victim-survivor said:

> "The time to provide support services is at or as close as possible to the time of the commission of the crime. A great deal of damage and loss of quality of life occur between the time of the crime and the time of provision of support services irrespective of the efficacy of the support provided."

Thank you, Chair. After the break, we will hear from the government panel.

CHAIRPERSON: Thank you, Ms Ryan. We will now take a 15 minute break so that we can get everything ready for the government panel. We'll come back at quarter to 11.

<THE HEARING ADJOURNED AT 10.28 AM

<THE HEARING RESUMED AT 10.48 AM

CHAIRPERSON: Yes, Ms Ryan.

MS RYAN: Thank you, Chair. We now have representatives from relevant government departments who will participate in a panel, giving evidence about the support services that are currently available for victim-survivors of child sexual abuse. Perhaps before they are sworn in, I will introduce the panel. We have closest to you, Chair, Ms Kate Rattigan who's the Deputy Secretary of People and Executive Services of the Department of Education. We have Wendy Sanderson, the Acting Director of Victim Support from the Department of Justice and Community Safety. We have Bill Kyriakopoulos, Deputy Secretary, Police, Community Safety and Corrections from the Department of Justice and

Community Safety. And we have Jane Sweeney, the Executive Director of Family Services, Evidence and Quality Improvement from the Department of Families, Fairness and Housing. And we have Kelly Stanton, Executive Director, Program and Service Development, from the Department of Families, Fairness and Housing.

CHAIRPERSON: Good morning, everyone, and thank you for taking the time to be here today.

MS RYAN: Chair, is it intended that they - the witnesses will be sworn in or -

CHAIRPERSON: Yes.

<WITNESS KELLY STANTON, AFFIRMED

<WITNESS JANE SWEENEY, AFFIRMED

<WITNESS BILL KYRIAKOPOULOS, AFFIRMED

<WITNESS WENDY SANDERSON, AFFIRMED

<WITNESS KATE RATTIGAN, AFFIRMED

<EXAMINATION BY MS RYAN:

MS RYAN: Thank you. Chair, this panel's evidence is relevant to the inquiry's consideration as to whether there are effective support services for victim-survivors in government schools. The panel is comprised of representatives from three different departments, and the various departments provide, or are in charge of, a range of different services.

It's intended that this morning's panel will operate as following, in that I will be asking specific questions to relevant department representatives, but also that at any time any other of the panel members can feel free to chime in, effectively, or answer the questions if it's relevant to your area of responsibility.

CHAIRPERSON: Yes. And I would really encourage each of you to do that. If at any point you feel like you have something to say or an observation to make, please do take up the opportunity to share that with us.

MS RYAN: Three of the witnesses have provided witness statements. So perhaps if we deal with that matter first. Ms Rattigan, you have provided a statement dated 3 November 2023 to the Board of Inquiry; is that correct?

MS RATTIGAN: Yes, that’s correct.

MS RYAN: And are the contents of that statement true and correct?

MS RATTIGAN: Yes, that's correct.

MS RYAN: And Ms Stanton, you have provided a statement dated 9 November 2023 to the Board of Inquiry. Are you satisfied that the contents of that statement are true and correct?

MS STANTON: Yes.

MS RYAN: And finally, Ms Sweeney, on behalf of the Department of Families, Fairness and Housing, you've provided a statement to the Board of Inquiry dated 10 November 2023.

MS SWEENEY: Yes, that's correct.

MS RYAN: And Ms Sweeney, I understand before we can commence - we commence, you wish to make an acknowledgement.

MS SWEENEY: Yes.

MS RYAN: Thank you. Please go ahead.

MS SWEENEY: On behalf of the panel we acknowledge the Wurundjeri people, the Traditional Owners of the Country that we are here on today, and we pay our respects to their Elders past and present. We acknowledge all victim-survivors of child sexual abuse, their families, supporters and communities, including those who have not yet disclosed the abuse they experienced. We recognise that child sexual abuse causes significant harm and can have substantial lifelong impacts. Thank you.

MS RYAN: Now, before we get into the substantive questions, can I just remind each member of the panel to speak into the microphones for the broadcast, but also for the transcript, and that it's important that when answering a question, you answer it verbally rather than just a nod or a shake to the head - a shake of the head. Thank you. So now, Ms Rattigan, I will start with you as Deputy Secretary of the Department of Education and referring at some - in some parts to your statement. In your statement, you have set out the support services provided by the Department of Education that victim-survivors have access to relevant to child sexual abuse in government schools. If I can ask you first of all, you've set out there in paragraph 6 what support services that the Department of Education refers victim-survivors to. So can you tell the Board about that matter first?

MS RATTIGAN: When I think about support services, I'm understanding them to be of the nature of therapeutic counselling and like services. And in the context of victim-survivors, I'm referring to victim-survivors of historical sexual abuse. And there are two main ways that - two key roles for our department in that. One is providing information and referrals to victim-survivors of historical abuse who

approach us or seek information from us via our website. And the second way is that we participate in the national redress scheme that provides counselling and psychological services. They're the two key ways that we're involved.

And the reason that it's limited to that is part of the reason is why I've got colleagues here today from the DJCS and DFFH and that is that the State delegates responsibility to different departments for different functions, and so our primary function is around early childhood and school settings, as the steward of those systems, the regulator and provide assurance over the systems. And the second reason is - that our role is limited is because we run and operate Victorian government governments, so the 80,000 - 85,000 staff and 650,000 students. But we do refer to the other departments who provide specialist support services, both to victims of crime and also to very, very specialist sexual abuse and sexual assault services.

MS RYAN: One service that the department itself does provide, as I understand it, is a counselling assistance payment scheme, referred to as CAP; is that correct?

MS RATTIGAN: The counselling assistance payments were set up in 2006, before the National Redress Scheme was introduced and before there were the two landmark inquiries that we've heard about through these - this Board of Inquiry, really as a stopgap measure. It has continued as a stopgap measure because, since redress has come in in 2018 and since there's been a strengthening of services available across Victoria, it's really there for those people who might seek some immediate reimbursement or payment on invoice, but it's not a program in a sense of the programs of my colleagues here that we'll be talking about today.

MS RYAN: So in terms of it not being a program, you described it as it providing reimbursement.

MS RATTIGAN: Correct.

MS RYAN: Do I take it from what you've said it's not - its utilisation is not as significant as the other services to which you -

MS RATTIGAN: Absolutely, yes. And I mean, I think there's probably one of the key reasons for that is that we do understand and we've heard that a lot of victim-survivors of historical abuse, because of the serious breach of trust that's occurred in the institutions, where the abuse occurred, some of them are reluctant to seek support from the institution responsible for that abuse. So that's probably one of the key barriers there. And so our experience has been that they've been seeking support from the agencies that are separate to the department and equipped to be able to do that.

MS RYAN: In terms of the CAP reimbursement scheme, if I can call it that, that is administered by the Department of Education.

MS RATTIGAN: Yes, the Department of Education, if we receive an invoice from someone in relation to psychological or counselling services, we would pay that up to 10 sessions. But as I said, it's very, very small; it's a stopgap.

MS RYAN: Right. And so you've said 10 sessions. Does that mean there is a limit of 10 sessions that will be reimbursed?

MS RATTIGAN: 10 sessions then to be reviewed and we have at times extended that.

MS RYAN: Right. And how does it work in practice. Can you just give us an overview?

MS RATTIGAN: Yes, in practice it's referenced in correspondence with individuals. It's - we've had a reference on our website. I've gone back to it at least 2015, I think it's been referenced there, but it has been in existence since 2006. And if someone is seeking assistance for counselling, they make an application, the application is made, very little documentation is required, a statement that the abuse occurred, and we would check that enrolment also happened at the time and that the perpetrator was employed at that time, and we would need referral from a medical practitioner recommending this particular therapy, and then invoices would be provided and they would be reimbursed. And that - but as I said, it's very - it's really a stopgap and it hasn't been greatly used.

CHAIRPERSON: The individual pays for the service, provides the invoice and is reimbursed.

MS RATTIGAN: Yeah, I don't run the scheme so I have - as to whether it's paid on - whether it's reimbursed or whether it's paid on invoice, it's either of those.

MS RYAN: When you say paid on invoice, do you mean directly to the -

MS RATTIGAN: Correct, directly to the - correct, yes.

MS RYAN: A psychologist or psychiatrist. And do you know whether there are any limitations to the type of services that are reimbursed under this scheme in the sense that can a victim survivor claim reimbursement from a psychiatrist as well as a counsellor?

MS RATTIGAN: Yeah, so I know that so far there hasn't been reimbursement for a psychiatrist based on my inquiries, but there's no reason why that couldn't occur.

MS RYAN: You've already told the Board, Ms Rattigan, that effectively it's not a scheme that has a significant take-up, if I can put it that way. At paragraph 16 of your statement, you identify some barriers to accessing counselling or services reimbursed through this CAP scheme. Can you tell the Board what the barriers were that you've identified?

MS RATTIGAN: I think the key barriers, the ones I've mentioned around, you know, the understandable, you know, experience of survivors and their ability to or willingness or preparedness or ability to trust the institution that's responsible for the abuse, and so I think that's probably one of the key reasons why we haven't seen a big uptake, but I think the other key reason is the existence of other services that are available that are tailored and specific and fully funded and, you know, purpose - have been designed with that purpose.

MS RYAN: You've also said in your statement - this is at paragraph 16(e) - that:

> "Potentially a lack of awareness of the scheme may be a barrier because it was rarely used in the past."

Are you able to tell the Board whether the department has promoted this scheme to other support services, for example, to CASA, which is the Centre Against Sexual Assault.

MS RATTIGAN: Yes, so the department has publicised information about it on its public website. As I said, I can confirm that it has been since 2015 but possibly even before then. And it is also referenced in - with representatives of survivors who advocate on their behalf or have approached the department. And then as for letting other organisations know, I think that would depend on its - no, the other services that are available and really what is in the best interests of the - the survivor and we'll hear today about other pathways and other forms of support and counselling and therapeutic assistance.

MS RYAN: You said that the initial reimbursement, once a victim-survivor is accepted in the scheme, if I can put it like that colloquially, is up to 10 sessions and it is then reviewed. Do you have any idea of how many individuals have had reimbursement for more than 10 sessions?

MS RATTIGAN: I don't know the answer to that, but it would be - the scheme has been only used by a small number of people. I'm aware of at least one where that's happened, but I couldn't give you any further information.

MS RYAN: When you say only used by a small number of people, are you able to give the Board any idea of numbers per year?

MS RATTIGAN: Very, very small. And I think in recent times, I think this year we've seen a few people, but over the course of the scheme, you know, very, very small numbers.

CHAIRPERSON: Are you able to give a little bit more insight what you mean by small numbers? Are we talking less than 50, less than 10?

MS RATTIGAN: Less than 50, yes, and - yeah.

MS RYAN: And noting that you said the scheme commenced in 2006, you said this year a handful of people. Do I take it that - or a few people, do I take it that's about a handful of people then this year have accessed it?

MS RATTIGAN: Correct.

CHAIRPERSON: So in the lifetime of the scheme you think perhaps 50 people or so, I'm not bedding you down to numbers.

MS RATTIGAN: I - I know we can confirm 10. I don't have records or information that related to the earlier part of it, and I suppose I should clarify. It's counselling assistance reimbursement or payment that is a stopgap measure for people who haven't got other ways of, you know, receiving that assistance, but it's not a scheme in the way that you will hear from our colleagues today and so I think that's probably another reason why it hasn't been utilised.

MS RYAN: And when you say it's a scheme for people who have done it other ways of obtaining that assistance, is there any kind of hurdle a victim-survivor has to jump then in order to access that scheme, for example, prove to the department that they haven't been able to access other services?

MS RATTIGAN: No.

CHAIRPERSON: So it doesn't depend on showing that you can't have your needs met in some other way? If you want to access it you can, as long as you overcome the threshold requirements that you identify?

MS RATTIGAN: Yes.

CHAIRPERSON: I see.

MS RYAN: And, Ms Rattigan, you said in your statement that access to this service has only been expanded recently to family members of victim-survivors as secondary victims. Are you able to tell the Board what prompted that expansion and when that happened?

MS RATTIGAN: That occurred in the middle of this year, I think. We - we set up earlier this year a sexual harm response function in the department that was set up for the purpose of coordinating supports to current students and in relation to conduct by current staff, and so in the context of that, the staff in that function who have trauma-informed training and background and very experienced around dealing with sexual assault and sexual abuse and its - its implications for family members, recommended that it be expanded to those family members, and that's what we have done.

MS RYAN: Perhaps that's an opportune time to move on to the Sexual Harm Response Unit which you just mentioned which, as you say, was just implemented this year; is that correct?

MS RATTIGAN: Correct.

MS RYAN: And can you tell the Board what was the impetus for the development of that unit?

MS RATTIGAN: So the unit works in relation to current teachers and current students, and coordinates existing functions and existing supports in the department that have always been in place. So we've always had an employee conduct function, a communications function, an emergency management function, regional services functions, and related functions. And the purpose of this unit is to join the dots between those areas and to provide central oversight of the way in which responses occur in relation to current instances. So that was the purpose of it being set up. And it - in relation to current students and current staff, it doesn't manage those incidents, but really has a trauma-informed lens over the management of those incidents to make sure that everybody in the department who has a function that relates to that is aware of trauma-informed practice and putting the needs of the child, the individual and their family first.

MS RYAN: You've said in your statement at paragraph 23 that:

> "The Sexual Harm Response Unit's role now extends to any victim survivor of child sexual abuse in government schools, current or historical, irrespective of whether a current or ex-staff member was involved."

Can you just - first of all when did that happen and what caused that change?

MS RATTIGAN: Yep. So when the unit was set up, they had on their work plan a task to review the department's web page on report abuse if you're a current or former student. That's the page that I've been able to determine has been in existence since around 2015 but probably earlier in different incarnations. As part of their review of that page, and then also part of other people in the department looking at that page, we decided to add a phone number and an email address to a dedicated area of the department as opposed to previously the region being the key contact, and we added the Sexual Harm Response Unit as the key contact, which then opened it up for that unit then to take calls and emails for - from victim-survivors of historical abuse who weren't already involved in other pathways such as redress or civil claims.

MS RYAN: Right. So if a victim-survivor is involved in redress or civil claim, then is it the case that the Sexual Harm Response Unit will not respond to that person?

MS RATTIGAN: They would always respond to someone who contacted them, but that's - they haven't had people involved in those processes contact them, and that's not the purpose of it, because those processes have support systems and representation around them.

MS RYAN: And can you give the Board an idea of what the Sexual Harm Response Unit does. So is it a referral service? What does it do?

MS RATTIGAN: Yes. So in relation to current students and current staff, as I said, it has central visibility and oversight of all of the different functions that are involved in responding to allegations of abuse or, you know, criminal charges, et cetera. In relation to victim-survivors of historic abuse, which is that recent function, they have - key role has been listening. It's been about understanding what the victim-survivor is seeking. Every single person has been seeking something different, and they've tried to listen and understand, take a trauma-informed approach to what is the right information to give them about their options.

You know, some people have called and said, we - that they wanted to let us know about some abuse that occurred many decades ago. They didn't wish to take any action about it, but they just thought that we should know, and that was good that they did let us know. We could check if the person was still employed. We could check the Vic register, the Victorian Institute of Teaching Register, let them know about supports that are available, et cetera, and they said thank you, and that was that. Whereas other people have wanted information about, you know, say - and I can't think of the example off the top of my head, but information that is - we've been able to provide or give them.

The other role that they've had is assisting with apologies and acknowledgements. So working with victim-survivors around what in particular they'd like to have in their apologies or acknowledgement, any particular references or things that would provide meaning and would aid with healing, and they've carried out that role too.

MS RYAN: And just practically speaking, is it effectively, in its current iteration as it applies to victim-survivors of historical child sexual abuse, effectively a phone line that provides advice or refers the person to a service?

MS RATTIGAN: Correct.

MS RYAN: Rather than -

MS RATTIGAN: Not therapeutic services, not a service itself, correct.

MS RYAN: All right.

CHAIRPERSON: I'm interested also, I suppose, in how it might deal with a person who is seeking information to understand more about what happened, for

example, at the school they were at if they suffered abuse. As you know, we've heard from a lot of victim-survivors about difficulties accessing information, and it strikes me that some of the queries you might receive through this Sexual Harm Response Unit might be about how do I access information from the department about what went on at the time that I was at school and wanting to know more information about that. So are you able to provide some insight into what the response would be for those sorts of inquiries?

MS RATTIGAN: Yes. They could definitely listen and take that request in from a person, and then they would speak to other parts of the organisation to get a response back, so talk to the records team in the department about, you know, are there records, are those records able to be provided or shared? If not, why not? What would be the process for obtaining those records? So they could definitely seek that information and provide that to the individual.

I think that's a - that's a really good example, because whilst in the past I think the department has referred to the specialist services, sexual assault services, victims of crime services that are provided by other departments who are here today, what - what we will do with this new function is be able to understand if there's anything else that a person needs that might be specific to the department. So, you know, access to information, you know, potentially facilitating re-engagement or direct personal response, those kind of things.

MS RYAN: Do I take it, though, as it currently is, the relevant person who's working in the unit does not have authority to provide information to a victim-survivor, to which the Chair is referring, but would have - would perhaps -

MS RATTIGAN: They would triage.

MS RYAN: Would triage, not -

MS RATTIGAN: Yes, they triage the information, they speak to the area who would assess the request and then provide information about pathways. If it's personal information about the individual, usually that would be provided; that can be provided. If it's information that includes information about other people and then it's a process of understanding what are our privacy obligations to other people, how would we go about giving the individual what they need but then not creating any concern for any other person who didn't want their identity to be known or we were not able - where we were not able to share that information.

CHAIRPERSON: Just to take you up on that, if the department has taken a position, for example, on privacy or legal concerns or FOI, an inquiry through this unit won't result on a change of position in relation to those things but it provides a pathway for the person to get a response. Is that the position?

MS RATTIGAN: That's - that's absolutely right, yes.

MS RYAN: And are you able to say whether that has, in fact, occurred, or is your evidence in effect it has the capacity to provide that service?

MS RATTIGAN: It has the capacity to do that. I am aware, though, of before this unit was set up, the department would receive such requests and they would go to the records area and they would assess the request and provide the information where they were able to do that. And if they - if the information impacted on the privacy of others, then they would give advice about how to go about seeking that, whether it's through FOI or through - through a discovery process or whatever the process is that the person - that's available to them or that they're involved in.

MS RYAN: All right. Now, before we go to any further detail, Ms Rattigan, is there anything else - any other information you wish to give to the Board about the role of the Department of Education regarding relevant support services?

MS RATTIGAN: Thank you, Ms Ryan. The other observation I'd like to share is that what I've heard through the hearings - I've attended several days and have watched online and read the information, you know, that there are a range of consequences of the abuse that happened at the hands of people in authority who should have been protecting these victim-survivors, and that those impacts can be lifelong and that they can cause complex trauma responses. And so in that context, I - it is important as the government or as the State to make sure that we don't - that we build expertise in those particular areas, that we don't fragment services through duplication.

So, you know, in terms of whether the Department of Education, you know, should build that capacity to provide therapeutic services directly to survivors, I would say that I would be concerned around sort of the duplication or the fragmentation of that, and you will hear today from - about the expertise of my colleagues and the work that they do in building the capability of people with really specific clinical experience, people with very, very specialist expertise in supporting victims of crime.

And so that is what I think would be in the best interests of victim-survivors, but we certainly do have a really important role in providing information, providing re-engagement, providing acknowledgements, providing apologies and such.

MS RYAN: Well, perhaps if we turn to Ms Stanton now on behalf of the Department of Families, Fairness and Housing. Ms Stanton, can you tell the Board what support services your department provides?

MS STANTON: So the Department of Families, Fairness and Housing -

MS RYAN: Can I ask you to speak up and into the microphone, thank you.

MS STANTON: The Department of Families, Fairness and Housing funds specialist sexual assault support services across Victoria, and I'd like to talk about

four key services today. The first one is Sexual Assault Support Services. They are available across the State to all Victorians, so people of all genders, whether their sexual abuse is recent or historical. They are free and confidential and they are staffed by a workforce with deep practice and clinical expertise in child sexual abuse and extensive knowledge and connections across the relevant service systems that child sexual abuse victim-survivors need.

In terms of the actual service delivery, I would say I want to make the point that they are victim-centred, ie, they attend to the rights, wishes and needs of victim-survivors and very much driven by impact and trauma that arises from child sexual abuse and sexual assault. So they provide immediate crisis support for people seeking services, and medium and longer-term therapeutic interventions and counselling, and they provide a range of that.

They provide practical supports. So they have flexible funding available to them. That can be for a whole range of things. It could be for material goods. It could be for access to other types of services. It could be for child care to allow them to - to allow the person to attend groups or other services. It could be they support - utility bills, a range of practical supports.

They also have a strong role in understanding the service system that victim-survivors need to access and advocating with those systems and services, so that victim-survivors' voices are heard through that and they get access to those services. They - where the victim-survivor wants that, they will work with Victoria Police. They will work with a range of legal, financial, health and social services to make sure that people have access.

They will also do secondary consultation with the broader service system. That's really important because a victim-survivor may be linked with another service, and are wanting to continue to work with that service and they will provide advice about the impacts of sexual abuse and guidance about how they might work, and they also provide support for family members.

MS RYAN: Now, just, as - when you talk about these sexual assault support services that are provided, you've set out a table in your statement detailing 19 mainstream services provided. So are they the services that you're referring to?

MS STANTON: Referring to those services. I'm also referring to the Sexual Assault Crisis Line which is the State-wide after-hours support line that provides a crisis response after hours. And also in that table is Aboriginal sexual assault services that provide sexual assault services in a culturally safe, cultural - Aboriginal-led service.

MS RYAN: All right. So, Ms Stanton, it'd just be helpful for the Board to have an understanding of what practically these support services do when a victim-survivor engages with them. So we've got the table of the 19 support services ranging throughout Victoria, and so one of them, for example, is Bass

Coast Health in Inner Gippsland. So if a victim-survivor engages with that service, what happens effectively?

MS STANTON: They will work with the victim-survivor to understand their needs. They will work with the victim-survivor to understand what services they are wanting to access, what do they - what are their therapeutic needs and goals, and they will support that person in the service through counselling, a whole range of different therapeutic interventions, and linkages to other services.

MS RYAN: And what are some of the examples of other services that they might link that person to?

MS STANTON: It could be some of the services delivered through Justice, it could be the National Redress Scheme, it could be financial services, legal services, housing and homelessness services. There's a - as you articulated earlier, there's a suite of needs that victim-survivors present with, and it is about determining what those needs are and how they can best be supported to access those services.

MS RYAN: And so once a victim-survivor has engaged with one of these sexual assault support services, and, for example, requires psychological assistance from a psychologist, how does that work in terms of - does that person - does that individual then get referred by the service to a separate psychologist or is the psychological assistance embedded within the service? How does it -

MS STANTON: Sexual assault support services are staffed by typically psychologists and social workers. So they may be accessing that service within the agency or they may be seeking a psychologist with particular expertise and they're looking to refer that person to a psychologist external.

MS RYAN: And is there a limit to the services a person can access by way of both the amount of services and the length of time to which they can access?

MS STANTON: No, there's no - there's no limits to the time. It is about the goals that the victim-survivor is setting for what they want from the service and how that's achieved. We know, of course, that victim-survivors' recovering and healing is not linear. People are re-triggered by a range of things, and they can always come back for services, for further help.

MS RYAN: And in terms of gaining access to the service, the first time a victim-survivor needs to approach the service, does that person need a referral or can they go direct to the service?

MS STANTON: They can go direct to the service. So victim-survivors refer themselves, there are referrals through family members, through Victoria Police, there are a range of other services in the local area, through Department of

Education. So there are a range of ways people can be referred in, but the victim-survivor can call, walk in, contact via the use of technology.

MS RYAN: And you've stated that in 2022 to 2023, the sexual assault support services delivered support to over 20,000 victim-survivors. You've also given evidence in your statement about increasing demand and availability of those services. So can you tell the Board about that, please.

MS STANTON: There's been increasing community awareness around child sexual abuse and sexual assault, and that's seen an increase in people seeking help, which we think is a really good thing. Government's made significant investments in the sexual assault system, with that increasing demand, we're still seeing some delays in service delivery. What I want to say about that, though, is where a person is waiting for service, a sexual assault service will make contact with that person, look at what kind of immediate supports can be put in place whilst they are waiting for some of those deeper services.

CHAIRPERSON: When you say there's been an experience of some delays, what kind of delays are we talking about?

MS STANTON: I've got evidence in my statement about the waiting lists at June 2023.

MS RYAN: Ms Stanton, I can refer you to paragraphs 43 and 44 of your statement.

MS STANTON: Yes. So the average wait time at - during that time was 62 days for children and 72 days for adults. But I do want to stress that while people are waiting for counselling and other programs, there is contact with those victim-survivors and they are often offered some immediate interventions and referrals to other services while they are waiting. So it's an active and dynamic process.

MS RYAN: And with that wait time, is that a wait time for a particular support service that's required, as opposed to a wait time for the service to contact them? Can you just clarify that?

MS STANTON: That - that's a wait time to get - for their counselling and other support services that are offered at the sexual assault support service. It's not a wait time for contact.

CHAIRPERSON: So a wait time for the first proper meeting, though, with the service, is that - so if a person first makes contact, I assume that at a certain point they come in and have a first session which is a pretty significant meeting. Is that the wait time they're looking at although what you're saying is they might be contacted in the meantime?

MS STANTON: They will be contacted, I want to say that, and they will be offered what I would call brief interventions which might involve a meeting with a counsellor to say, okay, what can we put in place while you're waiting for some of the deeper counselling services.

CHAIRPERSON: Just again, to be clear, that wait time is really between the first contact made and the first substantive meeting with the service?

MS STANTON: It's a wait time for entry into counselling or group work services. They might meet with the services and they might have some immediate needs that the service will work with, so it might be a referral to the National Redress Scheme, it might be other sorts of supports, it might be referral to a drug and alcohol service. But it is the wait time for the counselling and other services that the sexual assault service offers.

MS RYAN: In terms of the role of the sexual assault services, is it limited to referring a victim-survivor to other agencies, or do the services themselves also engage with agencies to advocate for the victim-survivors?

MS STANTON: The staff at sexual assault services are typically called counsellor advocates. That is quite deliberate because they have a strong role in advocacy across services and the service system to make sure that the victim-survivors' voice is heard in that and that they are supported to access other services.

MS RYAN: You also mentioned the Sexual Assault Crisis Line Victoria; was that the second of the services that you wish to address?

MS STANTON: Yes. So that is the - as I was saying, the after-hours crisis line. So it takes calls from a range of people. It will provide kind of immediate crisis care and support. And then the following business day will refer into the local sexual assault support service. For calls that they get during the day, the person will be supported to access the sexual assault service locally.

MS RYAN: And you've set out in your statement that since July 2021, call volumes to that service have ranged from 1200 to 1700 contacts per month; is that right?

MS STANTON: That's correct.

MS RYAN: And so what's the third service that the - that your department provides?

MS STANTON: So as part of the suite of sexual assault services, we have multidisciplinary centres in some areas across Victoria. That's a co-located model that includes sexual assault services, police, child protection and with strong links to forensic medical, and its primary focus is providing coordinated crisis care for

recent sexual assault and child sexual abuse victim-survivors. All SASS services though irrespective of where they are in the State provide that coordinated and integrated care.

MS RYAN: The multidisciplinary centres are in - I take it, they're intended to respond to - is it more recent - well, victims of more recent offending; is that correct, or -

MS STANTON: They - they can work with people with historical child sexual abuse, noting that the sexual assault support services are part of the multidisciplinary centre because they can - when they disclose, they also may access the services, the coordinated care that a multidisciplinary centre delivers.

MS RYAN: And when were these multidisciplinary centres implemented?

MS STANTON: It was post the Victorian Law Reform Commission report in 2004 and they've been progressively rolled out over the years.

MS RYAN: And what is the intention in relation to them? What are they – what are they meant to do? Compared to the sexual assault support services that you've just been telling us about.

MS STANTON: As I was saying, they're a co-located model, and they provide immediate crisis supports to people. So you can also access that child sexual support centre service, you have police and child protection and sexual assault services co-located on the site.

MS RYAN: And so is it because of the fact that the police are co-located and the Child Protection Services, that - is it fair to say that would respond more often to the very recent victims?

MS STANTON: Yes, they would, and with a strong focus obviously on child sexual abuse.

MS RYAN: And I think we're up to number 4 then now.

MS STANTON: Aboriginal sexual assault support services who also provide that suite of supports that I talked about earlier with mainstream sexual assault support services. But they also bring cultural knowledge and deep expertise, of course, in the particular impacts for Aboriginal people in terms of colonisation. They also deliver therapeutic services that are Aboriginal-led and designed.

MS RYAN: Just going back to one question about availability of services. You've given evidence to the Board about the wait time currently, the most recent wait times figures in relation to the sexual assault support services. Is there any priority given to clients in acute crisis, or is it just a wait time when you make contact? Do you know?

MS STANTON: Both recent and historical child sexual abuse survivors can present in immediate crisis. So the national standards talk about responding to people that are in immediate crisis. So that is, again, a process where SASS services will look at the nature of the crisis, what can be put in place and we'll work to make sure that people's needs are supported.

CHAIRPERSON: I think Ms Ryan's question was really directed to whether if someone is in acute crisis, whether it's historical abuse or recent abuse, whether there might be an attempt to reduce the wait time for a person in that circumstance?

MS STANTON: Yes, there would be, yes.

CHAIRPERSON: Ms Ryan, I had a couple of questions for Ms Stanton. Would now be a convenient time?

MS RYAN: Yes.

CHAIRPERSON: Ms Stanton, we've heard some evidence in the inquiry about the gendered nature of impacts of historical sexual abuse, and we've also heard some evidence that there's been a lack of supports that are tailored to recognising those gendered impacts. Do you have any view about the support services that are provided that you've talked about and whether or not they are capable or do recognise those gendered impacts and have that expertise?

MS STANTON: So sexual assault is a gendered crime in many ways. The sexual assault support services, all of the ones I've talked about today, as I said, work with men and women. They work with historical child sexual abuse survivors of both genders, and they are deeply expert in the particular impacts for the survivors of both recent and historical, both men and women, and other genders, in fact.

CHAIRPERSON: Hearing what you've said about them working with men and women, but also working with historical and recent abuse cases, the evidence we've heard was really about a lack of tailoring or specific services that could address those matters. So of the services you've talked about, do any of them have a specific focus on male victim-survivors? That's my first question.

MS STANTON: So those services would work with the victim-survivor to understand their needs. But they also bring clinical and practice expertise around the differential impacts of child sexual abuse for men and women. They will, from time to time, run men's groups or other services that are targeted at the particular experience of males that have experienced child sexual abuse. But all of their services, whether that's counselling or group work programs, are attuned to those different impacts for the different genders.

CHAIRPERSON: So are there any specific services? If a person says, "I would like to go to a service that specialises in abuse impacts on men", are there any that specifically focus on that? And the reason I ask you, just as a matter of fairness, is because we have heard evidence specifically about perhaps a deficiency in that regard, and so I want to give you the chance to address that.

MS STANTON: There are practitioners in sexual assault support services that are experts in historical child sexual abuse, particularly with males, and they will often be matched with those clinicians. And as I said, the range of client counselling and support services that they deliver, they will tailor that to the clinical need at the time. So they may have a group of men that are - have suffered historical child sexual abuse, and they will look at group work and other opportunities for those men, but they - each service will have clinicians that have expertise in that area.

CHAIRPERSON: So the answer to my question, I think, is there's no service which specifically focuses on male abuse survivors or historical abuse survivors. There's no service that takes that as its work?

MS STANTON: All sexual assault support services take that as its work, but there is no specific and different service for historical child sexual abuse survivors.

CHAIRPERSON: Yes, that's what my question was going to, whether there's a service that specifically focuses on that cohort as its mandate.

MS STANTON: Sexual assault support services have that mandate to work with historical child sexual abuse survivors.

CHAIRPERSON: But that as the sole mandate.

MS STANTON: No, there is not a service where it is the sole mandate.

CHAIRPERSON: The other thing that we've heard quite a bit of evidence about is a lack of expertise in relation to dealing with complex trauma, and that there are perhaps not enough psychologists or counsellors who have that kind of expertise. Is that something that you have a perspective on that you can share?

MS STANTON: In the pre-service education, through social work and psychology, there is a focus on trauma-informed care. In the professional development activities that practitioners in services participate in, again, there's a focus on trauma-informed care. The department released a trauma-informed framework for services this year and the Sexual Assault Services Victoria is doing a particular piece of research at the moment around trauma-informed care and what are the kind of gaps and opportunities to build capability for sexual assault support services.

CHAIRPERSON: So would you agree that there's a gap in relation to capability for complex trauma treatment? And again, the reason I'm asking you is we've heard a lot of evidence about that. So I really would like to give you the opportunity to say whether you think, yes, there is a gap or no, if so and explain why.

MS STANTON: Many people that present to sexual assault support services have complex trauma and a range of service needs. The staff that work in those services have deep clinical and practice expertise in relation to that trauma. But there is always further work to do to build the capability of the workforce around complex trauma.

CHAIRPERSON: And so you see there is a need for further work to be done in that area.

MS STANTON: I - I - I think that the work that SASS Vic is doing around that research will help us understand what that work would look like.

MS RYAN: Now, Ms Sweeney, if we turn to your evidence, you've given evidence really directed to two services offered through Victoria's participation in the National Redress Scheme, being direct personal responses as well as counselling and psychological care. So can you tell the Board what your department provides in relation to those services?

MS SWEENEY: Thank you. The department provides and is the department with responsibility for delivering the counselling and psychological care component and the direct personal response component under the National Redress Scheme. So Victoria participates in the National Redress Scheme and people who are eligible to apply under the National Redress Scheme include historical victims of sexual abuse in institutional settings. Department delivers, once participants have applied under the National Redress Scheme and been successful, they can tick to receive counselling and psychological care supports and then also opt to have a direct personal response from an institution. So I'll cover the counselling and psychological care first.

We provide a service which we redeveloped and stood up on 1 November, so previously we had consortium called Restore which is auspiced by south-east CASA, which is a sexual assault service, and we had a range of organisations that were members of that consortium. We now have a direct service response that is administered by the department following a significant review both done internally by the department but also reviews that had happened at a national level in terms of the National Redress Scheme, feedback from clients and people that were accessing that service.

Under the new service which we called the CPC service, people who have been successful or granted redress under the National Redress Scheme, as I've mentioned, can tick a box to receive that counselling and support service. So as

soon as that application is approved, they can then contact the service that we administer through the department. One of the changes we've made from 1 November is that you don't just have to tick that box. Anyone that's been approved under the National Redress Scheme can be proactively - we can proactively reach out to them and offer them services. And the way in which the services work is that they make contact with the department. We have navigator positions that then talk to the individual about what their particular counselling and therapeutic support needs and requirements are. We work with a range of providers who - we have transitioned a number of those services that were part of the consortium over to the new service. People then talk through with the navigators, there is an intake process, and we work through what is the type of counselling and support services.

Two of the, I think, really important things that we've done through the remodelling of this service has been to take out restrictions on number of hours in support. So it's unlimited. And we're guided by individuals around the types of services that they would like to access and for length of time. We also now can support family members. So before, family members were only able to access these support services if it was part of family group therapy, but now in their own right they are also able to access those services.

We've also looked at extending out the scope of services. So we have obviously access to psychological, therapeutic, psychiatric care, but also alternative therapies. We are looking at how we might build on best practice and evidence about what people's particular needs are, but we heard, I think, very clearly from many people that had used the service or tried to access the service, that it often wasn't just the support services through that sort of counselling and therapeutic, but alternative therapies were also really important.

We also support people recognising that they have complex needs and complex trauma. So we can also refer people that come into the service to case support and therapeutic workers that can then work across a range of service needs. So I think as my colleague mentioned, often housing, homelessness, referrals into other services, mental health, alcohol and other drugs. So we really work with that client, take a really trauma-informed approach, and really are driven by what are the needs of that person and how we sort of support that process.

In relation to the DPR, so that's the direct personal response program, that is very much an individual-led and voluntary part of the program. Under the National Redress Scheme, there are three components. So there is a monetary payment, the counselling component and then the direct personal response. Through that component, people can opt to have the institution that is responsible for the harm. So we administer that program for the State Government. So anyone that has been approved under the National Redress Scheme can opt to have a direct personal response which includes acknowledgement of harm from the responsible institution or department, a formal apology, and other - other things that might form part of that acknowledgement and apology.

They can form - they can be face to face, they can be letters, they can be both. Support people can attend those processes. And people may opt to have the apology framed. They can have plaques made up for their own personal use. It's very much on an individual basis and we are very much guided by the individual about how we do that. And it's navigated really carefully through an independent facilitator. So the department has a panel of independent facilitators that work with the individual about what is the nature of that process, and then there is a pretty significant process whereby we train executives across government in relevant departments. So they are trained in this process and how to give apologies.

Often people want to hear about what is the current and contemporary system doing now and what have the changes been. It's a really important part, not only for that acknowledgement of harm and apology for people for that harm that has occurred, but it's also a really important way that we take feedback directly from individuals about how we can design and improve our policies and programs, and a really important part of recovery and healing, most importantly.

We also - sorry, I've - just one more thing. We do fund a very specialist State-wide support services and advocacy services for pre-1990 care-leavers, so these are people who have been in institutional care and who have been harmed in those - in those settings. It's a smaller amount of people, obviously, but for the purposes of this inquiry, people harmed - sexually abused in government schools, they form part of that broader NRS response.

MS RYAN: A couple of questions about the matters you've given evidence about, Ms Sweeney, and then it might be an appropriate time for a break, Chair. Now, just in relation to the counselling and psychological care, you noted that there have been some significant changes made, particularly in the eligibility requirements; is that right? But also in the number of services that can be provided. Now, just to clarify, those changes are very, very recent, in late October.

MS SWEENEY: Yes.

MS RYAN: And early November of this year.

MS SWEENEY: That's correct.

MS RYAN: Is that right?

MS SWEENEY: Yes.

MS RYAN: Are you able to just to give a brief overview of how those changes will benefit victim-survivors?

MS SWEENEY: Yes. So I think we have enabled a service whereby we can add providers as appropriate to the provider list. So we don't have the consortium model. So it's a much - it's a direct service offering. People come and request and

talk to the navigators who are in the department, who then triage their requests and what their particular needs are. So someone may have an existing counsellor or professional therapeutic support and they may want to continue that support through this process. So they can have that provider, if they're not already on that provider list, can be added. Obviously they need to meet the requirements and the program requirements of the service, including accreditation, professional accreditation and those types of things.

We have lifted the limit on hours of support. It was previously 20 hours, but I think in recognition of, I think, the complexity of, you know, the trauma and supports that people require and the pace at which they may need to go, that's been a strong recognition that's consistent with feedback that's happened nationally under the National Redress Scheme. We've also been able to extend the supports to family members in their own right. So they are now able to access those supports for their own and individual basis.

We are looking at - we've now opened up the scope to include some alternative therapies. So art therapy, body somatic therapies, things that are sort of - we have some evidence on, but we are open obviously to looking at as we develop best practice and evidence how we might be able to broaden that out.

MS RYAN: Thank you, Ms Sweeney. Is that an appropriate time, Chair?

CHAIRPERSON: Yes. We'll take a break until 10 past 12.

<THE HEARING ADJOURNED AT 11.55 AM

<THE HEARING RESUMED AT 12.13 PM

MS RYAN: Now, Ms Sweeney, I've just got another question about the - your department's implementation of the Victorian government's direct personal response program which I undertake is accessed through the redress scheme. Now, I should say it's not this Board's role to examine redress arrangements. So I'm just interested in the direct personal response program. Is it the case that a victim-survivor can access a direct personal response either by through the redress scheme or by bringing a civil claim against the department? Is that how - are they the two avenues of access?

MS SWEENEY: So currently we administer the DPR, the direct personal response, as the department responsible for that under the National Redress Scheme. So that's the formal program we're funded for and deliver.

MS RYAN: Yes.

MS SWEENEY: In relation to civil claims, where they are settled with the department, we currently do not have a DPR process in place. We are looking at developing a policy and program to support that. So currently when civil claims

are settled with the department, there isn't a formal DPR program or response through that.

MS RYAN: Well, perhaps I will turn the question to the panel broadly and perhaps Ms Rattigan can answer it, but what I would seek an answer for is really, if a victim-survivor is not participating in the redress scheme, yet they wish to access a direct personal response from the Department of Education, how can they - is there an avenue for them to do it, and if there's not, can you comment on the benefit of there being one, effectively?

MS RATTIGAN: Yes. Thank you. It's very similar to my colleagues at DFFH in that for some time there's been two kind of key streams for engagement with the department. One has been through the civil claims process and the other has been through redress. It is possible for a person who - to lodge a civil claim and also make an application for redress concurrently, and they can conclude their civil claim, enter into a settlement agreement with the department and receive compensation and then activate the DPR, the direct personal response aspect of the redress scheme to have a direct personal engagement with the department. If they haven't already put an application in for redress, they can make one at that time.

I think that what we'd like to see and what we'd like to do and - and as Jane Sweeney from DFFH has said, is not to have to require a person who has been through that process, makes an application and goes through the paperwork for the redress scheme. What would be ideal, I think, is that they could conclude the civil process with us and that we would be able to offer a direct personal engagement of the nature that we've heard about today through the - that builds on the redress scheme that offers the person who is interested in it to have a re-engagement and apology and a direct personal engagement with - with a trained person from the department. We'd obviously need to, you know, be a decision of government if that's something that - that would be, you know, set up, but I could see the real benefits of that.

CHAIRPERSON: What about the cohort of people who are not going down the civil claims path, don't want to go down the national redress path, but may wish for an acknowledgement of some kind? Is that something you're also considering?

MS RATTIGAN: Yes, Chair. The sexual harm response unit has, since the middle of this year, been taking phone calls and emails from people outside of those two schemes. And listening to them and understanding what they're seeking, which is every person is different, everyone has sought different things, but that is absolutely something that they could facilitate and arrange.

MS RYAN: Thank you, Ms Rattigan. Now, before we move on to the Department of Justice and Community Safety, Ms Stanton, if I can just ask you to comment in relation to the sexual assault support services. Are you able to comment on any advantages or disadvantages that might arise to a support service which solely provides services to men? Do you have any comment on that?

MS STANTON: I think sexual assault support services have deep expertise across a range of child sexual abuse and sexual assault impacts and the service system that sits around that. So that's an important point. You've got a workforce that is focused on this work, and focused on all the people that experience the work. So I'd be - I'd have some - I think there are some considerations about the fragmentation of the system, particularly thinking about the impacts also for family members and others, again there's expertise in those services.

Those sexual assault support services are very well integrated in the local communities so they have that network of services that they work with to support the range of victim-survivors. I also think that they are accessible and known in their communities, and so people can go there and receive assistance to - with their experience of child sexual abuse and get support to navigate the suite of services that they may require. So I think they're important considerations.

MS RYAN: And in terms of the - are you able to say whether or how often the department evaluates whether the support services that are available are effective and are effective for the specific needs of the victim-survivor community?

MS STANTON: We haven't done any evaluations in the recent times. We've had a number of reviews over the last few years where we've taken that learning and applied that. We've also had the national body deliver standards that we'll be working to embed. We are about to commence - or are about to commence an evaluation of Aboriginal sexual assault services. We've also got a research program that's outlined in my statement where we are seeking to build the evidence base around the efficacy of this work and the experience - the lived experience of victim-survivors.

MS RYAN: And just for the benefit of the panel, we will be coming back to all the departments about reforms that have been taken - have taken place more recently as well as future reforms, just so you're aware. Now, if I can turn to the Department of Justice and Community Safety, and I'll direct the questions to Mr Kyriakopoulos and Ms Sanderson. So whoever wishes to respond, please go ahead and do so. Can you tell the Board what relevant services for victim-survivors are provided by the Department of Justice and Community Safety?

MR KYRIAKOPOULOS: DJCS provides a number of generalist services at an entry point for victims of crime. So it is for all victims of a crime, and that obviously includes victims of historical child sexual abuse. There are probably three services in particular that are most relevant to that - to that group of people, the first one being the Victims of Crime Helpline. It is, as I said, often a gateway for victims of crime, a first point of contact. We have trained professionals, trauma-informed professionals that will assess the needs of the individuals and then either refer to services or help them with advice. Sometimes it could be as simple as, you know, I don't know how to make a police report, other times it's I

need particular care or particular services. In the case of people that would be victims of child sexual abuse, we would most likely be referring them to services provided by DFFH, for example, sexual assault support services, and there's a variety of those depending on the particular case and the needs of the individual. You know, that is a service that doesn't require a police report to access, and, you know, we have a policy of trying to help wherever we can and refer whoever we can. People can opt in or opt out of those services at any time and we don't want people to be coming away without resolution or without direction. So we'd say no wrong door policy in making sure that we can provide direction for those individuals.

In some cases, we'll refer them to another service that we provide which is the Victims Assistance Program, that - we fund that service and it is provided by six community service organisations at locations across the State. That is more of a flexible case management service and it will be built to the various needs of individuals, whether it's emotional, psychological or practical. So they might refer to housing services, they might refer to a disability services. So that is a service that again people don't need to have filed a police report. So - and they are often co-located at - with police stations, for example, across the State. So that is also, you know, a - pretty accessible for all victim-survivors.

MS RYAN: Can I just ask a question about that. In terms of that service, you described it as a case management service and you described it referring. So is that a referral service as opposed to a service that itself provides counselling and support?

MR KYRIAKOPOULOS: I mean, it does provide. Look, it is basically a case management service, so it will look at the needs of the individual and help direct them, yeah. It doesn't necessarily provide specific services. Although Wendy -

MS SANDERSON: Yeah, so it's staffed by case workers and case managers who would hold the client and bring in the services around them or refer them to services and then coordinate those services for them, and that would include access to counselling and other supports, practical supports.

MS RYAN: And just to make it clear, in terms of the services that it - in terms of the services it refers to, be it counselling or support, are they likely to be services administered by the department, the DFFH?

MR KYRIAKOPOULOS: Other - other departments, yes, depending on the need, yes. And if I can, the third - the third is the Victims Legal Service which deals mostly to people that have, or are seeking to put in an application to the Victims of Crime Assistance Tribunal. So that is a legal service pretty much dedicated to those applications and those cases. It prioritises people that have been victims of sexual assault, sexual offences - sexual abuse, I should say. And that - that legal service is a relatively new one that began in March this year and

will ultimately deal to applications to the new financial assistance scheme which will replace VOCAT in 2024.

MS RYAN: And what was the reason for the implementation of that service?

MR KYRIAKOPOULOS: So it was a recommendation of the - just trying to remember which one it was. It might have been the VLRC report into sexual assault from 2021, and it recommended that legal assistance was required for a lot of people that are seeking - seeking assistance and having to go through the - you know, what is often a pretty traumatic and difficult process in going through the judicial system in seeking financial assistance.

MS RYAN: And in terms of the legal assistance it will provide, will it be limited to applications through the Victims of Crime Assistance Tribunal or is it intended that that legal service will provide any broader legal assistance?

MR KYRIAKOPOULOS: It is a limited scope as things stand, and it is mostly related to VOCAT applications, although as I said, once the new scheme comes into place it will - it will be geared towards applications there.

MS RYAN: And are there any other services that -

MR KYRIAKOPOULOS: Look, there are other services but they're less relevant to victims of child sexual abuse. We have the victims register which is where victims that have perpetrators in - in custodial settings, they can receive updates on developments, bail, appeals and so on, as they see fit. We also have an intermediary service which supports people with cognitive impairments and if they're having to - victims of crime themselves or providing a witness to. We also have the child and youth witness service which assists younger people in providing witness statements to the court.

MS RYAN: And turning back then to the Victim Assistance Program, which I note was established in 1997, the department in a response to a notice to produce document has identified some barriers to engagement of that service - this is at paragraphs 28 and 29 - and also some - set out there some recent improvements. Can you just touch on what barriers were identified and what, if anything, the department is doing to improve access?

MR KYRIAKOPOULOS: So I'll throw to Wendy in a moment, but we recently undertook a review of the Victims Assistance Program and appointed some new providers and changed some of the settings to make sure that the service was fit for purpose, and serving the needs of victims of crime. Now, that kicked off in, I think it was July this year, the new service providers were in place. So we've absolutely sought to improve the system, but Wendy can probably talk a little bit more about that.

MS SANDERSON: Yep. So the new - so we've changed the service model that underpins that, which underpins the new contract that kicked off on 1 July, so there's a number of significant changes in that. One is more flexibility in the way we provide case management and case coordination, there's flexibility in the brokerage and also in the case management hours to allow a more tailored response for people accessing our services. As Bill mentioned earlier, of course, there's some people that need a light touch and some people have that more complex needs over a longer period of time. So that new flexibility is built into the model.

We've also changed our performance indicators for those services, so they're now more focused on service outcomes, client outcomes and client satisfaction, which again sort of reorients the service to making sure they're giving some holistic support to people that come into contact with our services. We've also introduced a workforce capability framework that really embeds the requirements of our workforce to have the ability to undertake really trauma-informed, client-focused, victim-centred case management and program delivery.

MS RYAN: And when you talk about your workforce, are these the case workers and case managers you refer to?

MS SANDERSON: From VAP, yes.

MS RYAN: In VAP, okay. And again insofar as their involvement with victim-survivors, is it principally talking to them and helping them find effective supports, rather than giving them counselling, is that right?

MS SANDERSON: Yeah, but they'd work with a victim-survivor around some individual goals that they were wanting to achieve out of the contact and some of those might be help with criminal justice activities. Some of those might be counselling and support. And a number of other practical needs that people have in these circumstances. They would use the brokerage to access counselling which would largely be external, usually through SASS. Some of our agencies are co-located with the family violence and sexual assault services they might access counselling that way. They're not actually co-located; they're just funded for a different - so they're funded through the VAP program but also provide the broader family violence and sexual assault support services that DFFH do.

MS RYAN: And just to give some context to the recent changes, the department's noted in response to the notice to produce that there was a - the 2020 report in regard to strengthening Victoria's victims support service noted that some survivors - some providers, not survivors - providers were too focused on criminal justice tasks rather than victim support and recovery needs. So was that one of the findings that spurred this change, was it?

MS SANDERSON: Yes.

MR KYRIAKOPOULOS: One of them, yeah.

MS SANDERSON: Yes. And I should clarify that the case managers and case coordinators, they aren't purely providing transactional support to the people they're working with, the victim-survivors. They do offer in-service support, but it isn't the in-depth counselling, psychology, psychiatry that you would get through external services.

MS RYAN: All right. And from what you said, Ms Sanderson, do I take it that those changes have only very recently been implemented?

MS SANDERSON: The new - the new VAP contracts have taken place recently but I'd say they've seen an evolution of the expectations of VAP over a period of time.

MS RYAN: Yes. Yes. Okay. But in terms of, I suppose, if we talk about changes on the ground that a victim-survivor may be aware of or may have benefit of, is that very recently come into effect?

MR KYRIAKOPOULOS: I think it's important to say that while issues were identified with - with some of the providers and some of what was being provided, the services that were being provided, broadly it's always been - I mean, services have changed significantly since the day that the VAP were established. So, you know, it's a process of continuous improvement. I wouldn't say outside of changing of case managers or a new provider coming into a particular region that there would be necessarily a big change for - for people that, you know, receiving the services. But, you know, we have new expectations, new contracts in place. But, you know, the services were - were pretty sound beforehand, but there are - there are obviously improvements that we identified that we were keen to implement.

CHAIRPERSON: When have the new contracts come into place?

MR KYRIAKOPOULOS: July this year.

MS RYAN: And just if I can turn to the panel more broadly now, and in terms of each of your departments, whoever wishes to answer the question, please, do so. Can you tell the Board in relation to the services provided by your departments, just in brief compass really, how the landscape's changed since the period which the Board's been examining, being the 1960s to 1999, and how previous inquiries and reforms have affected the available service. So perhaps if we start with you, Ms Rattigan, and then - is there anything - comment you want to make about -

MS RATTIGAN: Yes, so in the period that's being examined by the Board, we identified obviously an absence of policies, procedures, you know, emphasis on creating child-safe cultures, and as - in connection with that, there would be an absence of support services available in direct response to child abuse. So if you

compare that scenario to today, so today not only are there systems, procedures, policies and trainings in place to prevent and respond to child abuse, but there's a focus on support services directly targetted for enrolled students and current students.

And then in relation to historical abuse, for victim-survivors of historical abuse, the big change that's happened since that time is the introduction of the redress scheme in 2018, of which the department is a participant, and that has seen a significant change in terms of access to counselling and psychological services and also access to a direct personal response. And we'll hear - I think my colleagues can talk more about the development of support services in a more general sense.

MS RYAN: Yes, Ms Stanton.

MS STANTON: So since rape centres kicked off in the early 1970s and with government funding, the first service in 1979, but through the 1980s and 1990s, those services were expanded. So since the 2000s, we've got sexual assault support services in all areas. They are part of an integrated service system at that area level, rather than individual centres. They're a system that works with all people that have experienced recent and historical child sexual abuse.

In terms of some of - there's an increased research and knowledge base with those practitioners and, of course, a professionalisation of that workforce, and there have been standards of practice over that time as well. In terms of some of those landmark inquiries and reports, the MDC, multidisciplinary centres were established on the back of the VLRC report in 2004, and that's a really important development in terms of the focus - critical focus on child sexual abuse.

The institutional - the Royal Commission into Institutional Child Sexual Abuse really made recommendations to all States and Territories that they should establish specialist sexual assault services for victim-survivors. Victoria already had that, but the Royal Commission really led to increased funding for sexual assault services, the establishment of Aboriginal sexual assault services, the introduction of flexible funding, and initiatives to support people with additional barriers to service.

MS RYAN: If I can ask you a question in relation to CASA, being the Centre for Sexual Assault which you mentioned being in place since the 19 -

MS STANTON: '70s.

MS RYAN: '70s, that's funded by your department. In terms of because we noted that there are CASAs all over the State of Victoria. In terms of a victim-survivor accessing the CASA and obtaining, say, counselling support directly through that CASA, is there any standard applied in terms of how much support that

victim-survivor can get, or is it up to the individual how the providers to determine what support's needed and - does that make sense?

MS STANTON: It does make sense. I might make the point that there's sexual assault support services, some of which call themselves centres against sexual assault, others have different names, so that's both a historical and a current name. There are not limits on the hours of service that they can provide and they will work with the victim-survivor to, as I said earlier, to understand their needs and develop their - their goals and work through them.

MS RYAN: And so, Ms Sweeney, is there any comment you want to make about -

MS SWEENEY: Yes, thank you. I think just building on Ms Rattigan and Ms Stanton's comments about obviously the Royal Commission was a landmark report, and I think the national redress scheme is a direct and specialist response to people who have been sexually abused in institutional settings historically. So I think one really important part of that what reform and Royal Commission did and the work that's followed is that it's really centred the voices of victim-survivors, and we continue to, you know, hear their stories, listen to what happened to them and build that into a service system that's trauma informed, and I think we continue to see, through, you know, the second year review of the National Redress Scheme and other like inquiries that really build I think the voices of victim-survivors and their experiences in their own right into the work we do.

MR KYRIAKOPOULOS: In pointing out that our - all of our services weren't around in the 60s and 70s, I think it's fair to say that there's been a significant shift in the way the justice system sets up and, you know, more focused on a trauma-informed response, victim-centric services. And I think it's fair to say that we use that lens through everything we do. All touch points in the justice system, whether it be, you know, victim support services but also the courts and working with Victoria Police, our corrections system.

As a result, you know, we had, for example, commissioned a review into the Victims of Crime Act and one of the outcomes of that was a recommendation to establish an administrative scheme for financial assistance for victims of crime, taking the scheme outside of the judicial system and therefore taking out the risks of re-traumatisation and the difficulties that people faced, risks of cross-examination, for example, so we as part of taking on that recommendation, were in that process of establishing that, and the financial assistance scheme will come into play in 2024. And I think there's a lot of positive elements in that, increased eligibility, increased financial payments that have - having to, through VOCAT, families, for example, considered as one application. Applications will be considered individually, by person, but I think to reiterate, I think one of the most important elements of it is that it does take it out of that judicial system which has been a barrier for many victim-survivors not wanting to go through that

process. So increased accessibility is going to be a significant element of the new scheme.

We've also - another positive reform that's come out of a review, the VLRC review in 2021 into sexual offences and sexual assault is we're currently working on an online reporting tool for victims of sexual assault or abuse. We're working with RMIT, Victoria Police, Family Safety Victoria as well. In doing that work, we're consulting with victims of crime. We have a victims of crime consultative committee that we are working on, with us on this, and we're still in the development stage. But again, that's another opportunity for people to be able to report crimes and be able to address these wrongs without having to initially talk to police or go down to a police station.

MS RYAN: And if I can just ask a general question to all of the panel, in terms of the support services that we've heard today are available and administered by the three government departments, can you explain to the Board how - if and how these services operate as systems of support were? Perhaps Ms Stanton?

MS STANTON: They operate - you heard earlier about the complex and multiple needs of child victim-survivors. The expertise around a range of those issues sits across a number of agencies, so having drug and alcohol or mental health or family support programs.

MS RYAN: I just ask you to speak up as well.

MS STANTON: Sorry. The sexual assault support services are really very knowledgeable and expert in the suite of services that victim-survivors may wish to access, and they support those victim-survivors to access a range of services. They also work with a range of service providers to understand what they are delivering, and to explain what sexual assault support services deliver. There are really clear referral pathways in and out of sexual assault support services. So at that local area level, they are working very closely with a range of supports and services to make sure that victim-survivor gets what they need, and that extends, of course, to the suite of services that my colleagues have talked about today, the National Redress Scheme and other schemes under Justice.

MS RYAN: In terms of the provision of those services and operated, you say, as you've described them, Ms Stanton, as a suite of services, are you able to just comment from - well, able to comment on what have been and indeed what are, as you see it, the biggest challenges to implementation of those services, and indeed reform of them?

MS STANTON: There's been rapid expansion in Victoria in justice, health, social services workforces, so recruitment and retention of workforce needs to be an ongoing focus for many of these services, including sexual assault support services. We've got, as I said earlier, increased community awareness, so there are increased numbers of people seeking help, and so that's a challenge for the service

system. And I think there's been, through these inquiries and commissions, a range of recommendations for change, and I think legislative change and reform takes time to embed. They're some of the challenges I would see. I also think there needs to be a continued focus on people that have other structural barriers to receiving help. I think about people with a disability or people from multicultural ethnospecific and faith groups and there's work that we need to do, LGBTIQ communities, in terms of their trust and confidence in the system.

MS RYAN: Perhaps I'll ask anyone else from the panel who wishes to address the question about challenges in terms of implementation of services and indeed reform of those services?

MR KYRIAKOPOULOS: Yes, I would reiterate the social services sector workforce is a challenge. We are - we are growing, demand is growing and the workforce is not always there, and retention and expansion of services means that we need that workforce. That's a pretty significant -

MS RYAN: And when you say workforce, can you just - is it from social workers to case managers? Is it the whole gamut?

MR KYRIAKOPOULOS: I wouldn't comment on the psychologist end of things but yes, definitely case workers and health line workers, case managers.

MS RYAN: And we might move on then to, really, future directions of support services. And if I can ask a representative from each department just to address what, if any, reforms are currently planned or underway in relation to the provision and access to support service for victim-survivors.

MS STANTON: In June 2023, the National Office of Child Safety released a minimum practice standard for specialist community support services responding to child sexual abuse. We've been working with the peak body, Sexual Assault Services Victoria, and our sector to embed those standards in practice and service delivery and we think that's a key task for us. The trauma-informed work, work around complex trauma, the department delivered a framework this year. Sexual Assault Services Victoria is doing a piece of research. We need to look at the learnings from that research and think about how we continue to build the capacity of the service system around complex trauma.

As I said before, we've got community members that do have additional barriers to service. So we are doing some work to strengthen partnerships across sexual assault services and disability services, multicultural services and LGBTIQ services. The work also needs to continue in relation to community awareness and knowledge of services. The peak body does a lot of that work, the local services do a lot of that work, but we've heard through this inquiry that people are still not clear about what they can access, so there's more work we are continuing to progress there.

There's also - there will also be work in relation to workforce, so there will be a workforce capability framework for sexual assault services and some work about recruitment pathways to sexual assault services. So they're some critical things that we are working on that we think will strengthen the system.

MS SWEENEY: And I might just add to that, I think I've talked about we have a new model for the counselling and psychological care, so really looking at that as we start to roll that out around increasing greater access but also the scope and remit of the types of supports people need. So really, I think, monitoring that, particularly where it looks at alternative therapies and broader supports for family members in their own right.

I think I mentioned earlier around the restorative engagement program where we are looking at how we might apply that where civil claims are being settled, and I think one of the things we're really interested in is looking at how we might think about bringing more formally the voices and experiences, insights from people with lived experience into the work we do, so not just in terms of that - when they're getting a service delivery but thinking about the design and development of policies and bringing them into earlier to those parts of the process.

MR KYRIAKOPOULOS: I would echo Kelly's points, that from the Department of Justice and Community Safety's perspective, we've got quite a bit of reform already underway. The financial assistance scheme, as I said, is in the process of being established and the online reporting tool expanding the Victims Legal Service but I would also add that we're always looking to do things better and to, the system's not perfect. We have a process of feedback and review and monitoring of our services. So it's something that we are always looking at from a victim-centric point of view. But I think awareness - and I think Kelly said that we've heard that today, but I think awareness of service is obviously something we need to consider and look at and how better to do that. We are pretty well connected to our service providers and partners at the, you know, local government level, State level and so on, but I think there's definitely consideration of whether enough people know that these services are available for them.

MS RYAN: Ms Rattigan, is there anything you want to say from the Department of Education's perspective?

MS RATTIGAN: Ms Ryan, there's two things that I'd like to mention that the Department of Education is exploring. And that is really in direct response to the feedback that we've received from victim-survivors in the Beaumaris - victim-survivors of abuse at Beaumaris Primary and what we've heard during these hearings. So it's very, very early in terms of our exploration.

The first goes to - and I'd just like to express my gratitude to some quite brave and courageous people who have put these matters - drawn my attention to these matters and engaged directly with me. That has got us in the organisation really thinking about how we can adapt and be responsive to particular needs.

The first is offering - we'd really like to be able to offer a direct personal engagement opportunity to victim-survivors who are seeking to re-engage with the institution. Not everybody wants to do that, but for those who are, who have - who are going through a civil claims process, that process of itself is challenging and difficult by its nature. When that's concluded, I think there - if people are seeking it, we would like to be able to offer a senior person in the department to meet face to face with a survivor if that's what they would be seeking, to listen, and to understand what happened. You know, it's really important for the department to reckon with its past, to learn, and to be present in that engagement with the survivor that's face to face that's not through a civil process, and to express regret and to apologise directly, and also to reassure in terms of the steps that the department is taking and will continue to take to prevent and to protect and to respond to child abuse currently.

If government decides to introduce a program like that for us, we would - we would need very skilled and trained facilitators, and I think we've heard from my colleague here calling this a navigator concept, because a trauma-informed approach to direct personal engagement would necessarily involve it being very, very victim-centred. So it would be up to that - the victim-survivor as to when, how they'd like that engagement, what it would look like, who they would like there. It might - they might start the process, and then stop the process, continue, pause, or withdraw. And all of those options are available, but I think it would just need independent, dedicated people who are not employees of the department to facilitate that restorative engagement process, and then a written apology could be part of that as well or other actions. So that's something I've been talking to my colleagues at DFFH about and they're also interested in that too for their civil claims.

The second thing that we're sort of looking at is that what we heard through the hearing and what we've heard through correspondence with the victim-survivors at Beaumaris is that truth telling and information is really critical to healing and it's very limited with poor historic records. It's really limited by, you know, past recordkeeping practices and poor storage conditions of records in schools. We have currently 1500 schools. Over time there've been many, many more schools that have since closed, and those records are so valuable and they are so important to victim-survivors of abuse.

And what we would like to do is to commence a kind of big reform around digitisation of those records so that they can be digitised, catalogued and then potentially, depending on the nature of the record, made available through - either through PROV, the Public Records Office Victoria or through our school history website where they're of a nature that can be shared. So there are, you know, pupil registers and photos and things like that that can be shared. And for information that can't be shared publicly but could be made available to someone through other processes, as happens now, we would be able to very quickly get access to that information and provide it in a much more responsive way than what we do now,

because of the variable condition of school records. So they're the two things that are - that we've really learnt from the survivors here that would be important.

MS RYAN: And if I can direct a particular question to the Department of Families, Fairness and Housing, and perhaps Ms Stanton, I think it was your evidence about the department supporting these sectors to embed standards. Can you just give the Board some more detailed information about how the department is doing that and what the department is doing?

MS STANTON: Okay. So with - in terms of our - we fund agencies and we manage our relationships with those agencies through a service agreement that is managed at the local operational level in DFFH. Those - that service agreement has a range of standards that would apply to all agencies, you know, child safety standards is an example of that. And then there are particular standards relevant to the work that they do. So currently there are standards in their service agreement that need to be updated on the basis of the new standards that have come into play.

We would also be working with the sector to look at what needs to occur with the sector for those standards to be embedded in their practice and service delivery. Many of them are already, but some of it is about training, some of it is about information to other service providers. So we'd be looking to work with the peak around what actions do we need to take to make these standards embedded in the service.

MS RYAN: And in terms of the standards being updated in the service agreement, does that happen when the service agreement expires and it's due to be renewed, or does that happen while the service - while the particular service agreement remains operational?

MS STANTON: It's really led by when some of those expert standards become available. So the latest ones are from June 2023, so we would be looking to embed those in the - in the service agreement. Sometimes that coincides with the expiration of a service agreement, so you would do it at that time.

MS RYAN: Now, we've heard evidence from the panel in relation to a whole variety of services. Many of them are provided generally for victims of crime or for victims of sexual assault generally. Now, as you're aware, this Board is concerned with victim-survivors of abuse in - child sexual abuse in government schools, accessing support services. Now, you've - some of you have touched on identifiable barriers for those victim-survivors to access support services. I'd just like to give you an opportunity to make a comment, not repeat anything you've already said, obviously, but whether anyone wants to make a further comment on how accessible the support services are to this cohort and what, if anything, can be done in your view to overcome any barriers that you've identified?

MS STANTON: I'd also like to add that those services deliver in a range of ways. So outreach, Telehealth. I'm conscious there are people that live in rural and

remote areas where coming into the centre isn't always possible for them. So they make their services accessible through that. I think, as I said earlier, there's some more work that I think we need to do collectively to help historical child sexual abuse victim-survivors understand that this service system is for them. I also think that there are many historical child sexual abuse victim-survivors that have used these services and have had positive and helpful experience. So just thinking about what my colleague said, how do you harness that lived experience to build confidence - build more confidence in the service system.

MS RYAN: Anyone else wish to make any other comment about -

MR KYRIAKOPOULOS: I was wanting to say - I wouldn't want to comment on specialised services, but I think it is important to have general - generalist services and appropriate that the services that we have and the referrals, and I think that it does work well. I think there's - as I said earlier, there's always room for improvement but I think the referral systems work well, the referral systems are integrated well, but again coordination and integration can always be - can always be improved.

MS RYAN: Thank you. Chair, there is, of course, more detailed information that's been provided to the Board in the three witness statements of Ms Rattigan, Ms Stanton and Ms Sweeney, as well as evidence prepared or evidence given by the Department of Justice and Community Safety and response to the Board's notice to produce, and they are all the questions that we have for this panel.

CHAIRPERSON: Thank you. I just had two further questions. Just to circle back to a topic that you asked the panel about, and this is for Ms Rattigan. Ms Ryan asked some questions about changes that occurred over time in relation to services, and some of the drivers for those changes. In your report and also today, you've given some evidence about what - about the Sexual Harm Response Unit and I'm curious to know, given that it's been introduced in early 2023, what prompted the establishment of that unit?

MS RATTIGAN: The area where that unit sits, they acquired responsibility for a school review function which reviews compliance with minimum standards and Child Safe Standards so they started building capability in relation to Child Safe Standards and school compliance, which then gave them a bit of a birds eye view in terms of the value of having a central part of the organisation being able to join the dots in relation to how the department is responding to incidents. So it really came from that - that context, and that's, in fact, what they do. So ensuring that we have essential visibility, essential record and that we are ensuring that there's consistency in the approach. Because we have, for a really long time in the department, been very focused on response and protection and prevention, but it's a very large system. There's more than 1500 schools, 650,000 students, 85,000 employees. So, you know, bringing it - bringing that visibility in just allows us to have that extra level of assurance.

The other thing I wanted to mention too is that many things have happened that - adjustments and changes we've made over the last couple of years around our approach to apologies, the setting up of the unit, and so - and our approach to assessing compliance. So much of it has actually been informed by advocacy from survivors, victim-survivors of historical abuse, that we have been - become aware of. It's really sharpened our focus around current - the current state. And I just would like to express my deep appreciation and gratitude for the courage and bravery of people coming forward because it's really, really important as well that we can keep looking back and learning from that, and making sure that our current responsibilities to current students are a real focus for us and that we've learnt from the past.

CHAIRPERSON: Thank you. Do you have any further questions, Ms Ryan?

MS RYAN: No, Chair.

CHAIRPERSON: I don't have any either, probably to everyone's relief. I wanted to thank each of you for coming today but also for the work that went into the statements that we've received. It's really important for everyone here to be able to hear directly from those involved and who have oversight. So thank you very much for your time and for participating. We're going to break for lunch. We'll come back at 2 o'clock.

<THE WITNESSES WERE RELEASED

<THE HEARING ADJOURNED AT 1.07 PM

<THE HEARING RESUMED AT 2.01 PM

MS RYAN: Thank you, Chair. The inquiry now calls Dr Peter Rob Gordon.

CHAIRPERSON: Thank you. Good afternoon, Dr Gordon. I understand you'd like to take an oath.

DR GORDON: Yes.

<WITNESS PETER ROB GORDON, SWORN

<EXAMINATION BY MS RYAN:

CHAIRPERSON: Dr Gordon, please make yourself comfortable, and if at any point you need a break, please just let us know and we can take a short break.

DR GORDON: Thank you.

MS RYAN: Thank you, Dr Gordon. Is your full name Peter Rob Gordon.

DR GORDON: Yes.

MS RYAN: And your professional address is at Station Street in Box Hill North?

DR GORDON: Yes.

MS RYAN: And you are a practicing clinical psychologist, having graduated from Adelaide University with a Bachelor of Arts with Honours in 1970 and then obtaining a PhD from the University of Melbourne in 2003, and you're a fellow of the College of Clinical Psychology, Australian Psychological Society.

DR GORDON: Yes.

MS RYAN: You have since about 1976, or from 1976 worked at the Royal Children's Hospital as a psychologist, first as a psychologist and then from 1980 as the deputy chief psychologist and from 19 - until 1989 and then from 1989 to 1999 as a sessional psychologist; is that correct?

DR GORDON: Yes.

MS RYAN: And from 1989 until the present day, you've worked in private practice in clinical psychology?

DR GORDON: Yes.

MS RYAN: You continue to conduct your private practice as a clinical psychologist.

DR GORDON: I do, yes.

MS RYAN: And relevant to this inquiry you have particular experience in treating individuals who've suffered trauma, both by way of emergencies, disasters, as well as sexual abuse; is that correct?

DR GORDON: Yes, that's correct.

MS RYAN: And for the benefit of the Board, you've set out your qualifications and experience, and indeed your lengthy curriculum vitae in your statement of 22 November 2023?

DR GORDON: Yes.

MS RYAN: And in that statement, you've provided evidence to the Board in relation to the impact of child sexual abuse as well as relevant evidence in relation to support services relevant to victim-survivors of child sexual abuse?

DR GORDON: Yes.

MS RYAN: And are the contents of your statement dated 22 November 2023 true and correct?

DR GORDON: Yes, they are.

MS RYAN: Thank you. Now, Dr Gordon, if we can address - if we can turn first to the impact of child sexual abuse, and first of all the psychological impacts broadly of child sexual abuse on a victim-survivor, can you tell the Board your opinion as to the importance of contextualising the abuse in that a different character of sexual abuse when it's perpetrated on a child compared to when it's perpetrated on an adult?

DR GORDON: Yes, I think there's a particular quality for children in that the perpetrator usually has to engage the child through some cooperative means which involves some degree of grooming. In other words, the perpetrator creates an environment where they offer the child something that the child wants, and in that way draws them into a situation where they can then undertake the sexual abuse. Particularly young children have no basis really for understanding what's going on until it actually is happening. Even then, they have a lot of difficulty, particularly young children, primary school age, of really making sense of what's happening. It can be that the abuse will be painful and frightening to the child, but very often it's in the perpetrator's interests to try and keep it going as a - as a, shall we say an enjoyable, relationship, at least from the point of view of the perpetrator.

Now, this creates a particular conflict for the child because the enjoyable aspects of the grooming usually are wanted and enjoyed by the child, but they're accompanied by something that they feel as though it's unpleasant, but they're often told other things by the perpetrator. "This is our little secret" and so on. So this creates very deep confusion and easily encourages the child to distrust their own basic feelings that say, "I don't like this; this is not right." And often children in a vulnerable situation will be targeted. And so they're particularly vulnerable to really deep confusion in their relationships, their trust, their sense of identity and so on.

CHAIRPERSON: When you're referring to the enjoyable aspects of the relationship, we've heard evidence of things like being given special privileges at school or being taken on sporting trips.

DR GORDON: Exactly.

CHAIRPERSON: Something that responds to the child's own interests?

DR GORDON: Yes. And makes them feel special, rewards them, giving them a sense that they're getting something that's a real privilege and so on. So this - this creates a whole social context or a relational context that has to be opposed if you were going to say, "I don't like what you're doing to me", and it's very hard for a

child to make that stand, even for adults at times. So - so I think this is - this is sort of the beginning of the - of the insidious part of the - where you think of trauma as an injury, it's the injury to the core sense of self and the ability to speak for your needs and to be able to assert safety.

MS RYAN: And in terms of that injury, turning then to symptom manifestation, in your experience, can you tell the Board the - I suppose the range of symptom onsets in child sex abuse survivors and what that may entail?

DR GORDON: In - in fairly young children, often one of the dominant features is - often it's a sort of secrecy wrapped around it, and the child has a sense that something's wrong, so one of their dominant feelings is fear of being punished, "I've done something wrong, I'm bad." In various scenarios that will be reinforced by the perpetrator. But also the sense of the conflict between "this is our little secret", somebody that I - is - sort of evoked my loyalty, I'm going to have to go against that in order to, say, tell my parents. And this creates a conflict of loyalty, it's a conflict of knowing what's right. And so for young children, the sense of having done something wrong, being frightened of getting into trouble, "I won't tell anyone because I might get into trouble", becomes very dominant.

At an older age, say, through into adolescence, there's often a high degree of shame and internal guilt, "I feel so bad, I don't feel I can tell anyone." But it's also often the case that children who are in a powerless position when the sexual activity's going on, and may have very frightening experiences. They don't understand what this is on about. So young children will often equate sexuality with violence because they have no way of understanding the sort of arousal and the heavy breathing and all the other things that come with sex. They make this equation that something violent is going on, and so that often engenders high levels of fear and helplessness. And some children will dissociate at that point. They'll simply disconnect. I think of dissociation as the defence of last resort. If you're completely helpless, nothing else you can do, then you can at least blank out your experience.

So this sets up the situation where there's no clear memory. There's no memory laid down in the conscious part of memory. And that - one of the symptoms then is that when that's happened, there will be two things. One is the - the child will often repeatedly put themselves in that situation because they can't remember that something bad has happened, and that's a sort of repeated pattern. I've certainly worked with a - somebody who - a woman who, in her late primary school, found herself in a situation repeatedly in her home life - it wasn't a teacher on that occasion - and she - as soon as she was in it, she kept asking herself, "How come I put myself in this position?" Of course, she had no memory about the lead-up to it, so she'd only recognise it when she was in it.

So the dissociation produces that problem. The other side of it is that it will produce perhaps a healthier reaction which is a high level of fear and distrust and avoidance, maybe not wanting to go to school, high levels of distress that can't be

explained, and the child, of course, can't give an account of it, which, of course, can lead to punitive responses, the child doesn't want to go to school, they get sent to school, and so you get a whole circle of action and reaction where the symptoms started to be treated as problems, and then parents or teachers may be introduced. So in the old days, hopefully, more punitive authoritative approach to it. And all the time the child's just completely more and more bewildered.

MS RYAN: One of the other features you discuss in your statement, features of trauma, is this state of heightened arousal which then leads to cognitive consequences. Can you tell the Board about those consequences?

DR GORDON: So arousal just refers to the activation and intensification of mental neurological emotional bodily activity. So we talk about the adrenaline state. The adrenaline state specialises the brain for survival, and there is research going back to the 1950s that - that shows consistently there are two basic psychological gestures when we go into arousal. We go into a sort of tunnel vision on the problem. And in this case sometimes children will fixate on a part of their visual field, say, the pattern of the tiles, and then later on in adulthood that pattern will keep coming back in dreams or something. But they certainly are unable, and we are all unable to hold the whole context when we're in a high state of arousal.

The second one is a disengagement from the self and a focus in the external world. So people in high arousal are not able to focus on themselves. But this whole specialised state means you're in a mental state that's incompatible with the state we need to be in to learn, for instance, to concentrate, to remember, to do all the things that we would expect children to do in - in school, in education, because school should be happening when you're in your comfort zone and you can use all your faculties.

So very often children that are severely underperforming at school, who are - and I've certainly worked with - been working with a boy who had been abused and - he could not bear mathematics because he couldn't do mathematics, and so he would be trying hard to do it, he would be flooded by memories, and it's like in the most difficult activities, you - you have to put your whole sort of attention onto them, but that means you take the attention away from managing and containing. This boy did remember very clearly what happened, but you kind of lose that defence, the energy that's being applied to manage your internal world and then you get flooded by the memories. And so he would, of course, kick up and refuse going.

And children in this situation will often tell you it is much better to do something, swear at the teacher, something, get kicked out of the class and be sent to the principal, he's a nice man, he'll let me just sit in his office for a while, and so that's far more preferable than struggling through a maths class.

So in this way again, you get a whole range of problems that interfere with learning and - and also peer relationships, because the child carries this sense that

"I've got something in me that nobody else understands. I look at all the other kids playing around having a happy time and I feel this huge weight of a secret and I can't join them, and I don't know how to talk to them about it so I'm just different." So virtually any area of a child's development can be derailed by this, depending on when it happens.

MS RYAN: And, Dr Gordon, we've got the benefit of you having worked at the Royal Children's Hospital from about the mid-1970s. Can you tell the Board in your experience about first of all how child sexual abuse was handled then in terms of your clinical experience in a hospital setting, and what you consider the impact of that was on victim-survivors at that time?

DR GORDON: Yes. So around about the time I started at the children's hospital, they established a short-term inpatient assessment unit. And I was asked to take the role of the psychologist in this unit, which I had for 12 years. When we started, there was no State child protection system. Child protection was managed by the Children's Protection Society, which still exists but is a charity, and was managed really as a medical welfare-type problem.

And many of the children who were injured would go into the wards and have their injuries dealt with, and then they'd be referred down to our unit to be assessed, and decisions made about where they would - where they would live and what would happen and maybe engaging in a therapeutic program. And it was only some way into it, as a result, I'm pretty sure, of a major campaign by the Age - did they call it something like "our nowhere children" or shame or something, they had some - and they just kept putting out story after story of child abuse, and it was as a result of that that I think it was the Hamer government that set up a child - the first child protection system.

And once that happened, we didn't get quite so many referrals and they would be picked up by the child protection system. But - but looking back, it's amazing that child protection is a relatively recent phenomenon in our, you know, social development.

MS RYAN: You've provided an example in your statement of when you were working at the Royal Children's Hospital in the late 1970s, and children would come in with bruises and the physicians would effectively speculate on a potential blood disorder and in the sense that they were not then thinking or comprehending -

DR GORDON: Yes.

MS RYAN: - that these children might everybody abused. Can you expand on that?

DR GORDON: So at that time the medical staff had a lot of difficulty accepting that injuries would be nonaccidental. And I can remember sitting - they used to

have a grand rounds where all the medical staff would come to the big hospital theatre and we were encouraged to go to understand what was going on. And they'd put up these X-rays and have all the clinical details of children that had lots of bruises. And then they would go into the blood chemistry trying to work out what is it about the blood in these children that makes it so readily bruised. And on that basis, the parents would be saying, no, nothing's happened, they've just fallen off a little coffee table, and yet they've got serious bruises and injuries.

And then slowly - and I remember Terry Brazelton who was one of the United States researchers that really made physical abuse a major issue, he came out and presented his research and so on. And so there was a - a sort of gradual shift in their understanding and a recognition they needed to develop protocols for nonaccidental injuries.

But as - and - and it seemed to be about, after a couple of years of this, of course, the clinical work with these children often revealed that there was sexual abuse going on, and so children with repeated genital infections and things of that sort. And I can remember sitting in a meeting where the - I think the psychiatrist was saying, "We believe there's sexual abuse going on with these children." And I can remember the - some of the physicians saying how - they can't believe it, "How could people do that to their children?" There was sort of a degree of incomprehension.

And it was only after a few more years of gradually increasing evidence and the children's hospital brought people out from overseas who had done the research that there was a - there was a sort of a shift. And so probably by the early '80s, there was a kind of recognition of abuses being physical and sexual and that we really needed all sorts of protocols and indicators to pick this up.

MS RYAN: And, Doctor, turning back to the impacts of child sexual abuse, if you could tell the Board in your experience what are the particular impacts of child sexual abuse, when it is perpetrated by teachers?

DR GORDON: So the problem here is that a teacher is a - should be a trusted person who's got the guidance of the child, who's got an authority, and school ought to be an environment where children feel safe and can, apart from an education, get on with their social development, make friends, enjoy themselves, which is such an important dimension of human development generally.

And so once a teacher is doing this, I think it creates a - a total confusion in the mind of the child, which will result in either this sense of "I'm a bad person, I'm doing the wrong thing, I don't quite understand it", or this deep sense of distrust for adults in positions of authority. And, of course, that's going to undermine relationships right through the rest of their educational life. And often children will put a screen of bad behaviour, defiance, aggression or whatever, so that they put a lot of conflict between themselves and the - and people in authority, because

it's sort of safe behind that. But, of course, at great expense to their own development.

MS RYAN: In terms of their development, what if any impact can it have on an individual's employment or educational and employment trajectory?

DR GORDON: You know, I think there are several things. First of all is the pure failure of academic achievement because of this high arousal in the brain and the inability to concentrate. But a second aspect is the damage to identity. "I don't know what's important, I don't know what I should be doing. I've somehow disengaged myself from what was important because I'm in a kind of survival mode all the time." So the ability in that survival mode to have interests, enjoyments, long-term hopes and plans, it all gets lost. So there's no motivation, no - I'm speaking in, you know, black-and-white terms, but the whole mechanism of engagement, motivation, hopes, goals is undermined.

If - if you've got a good communicative environment in the home, then the child will come home and talk about it and they'll get picked up and - and helped. Very often the children that are most vulnerable are children where there isn't a good open communicative environment in the home, and so they either come home and tell it and are not believed or they don't say anything and if they're dissociated they don't say. So the whole process of getting into employment may trigger the - in psychotherapy, you talk about the transference, the transferring of patterns of relationships from early relationships to later relationships. So it would be very predictable that someone who's had abuse from an authority figure may take great exception to a supervisor or a boss at work telling them something, and they would arc up in a very - what appears to be a very unreasonable way, and their employment certainly doesn't prosper; they may get sacked or something. So plus their inability to focus.

And the other thing I would say is the self-criticism, even people - kids use the term self-loathing, a very strong term of how badly they feel about themselves. If you don't feel good about yourself, then the ability to take pride in your work and to be motivated to do a good job, all of these things don't make sense once you take that sense of value of yourself out of the equation.

MS RYAN: Doctor, you've touched on the impact of child sexual abuse on employment. Can you tell the Board, in your experience, what are some of the impacts of it on a person's ability to establish and maintain relationships, whether it's friendships or intimate relationships throughout their life?

DR GORDON: It's very, very challenging. Because of the self-loathing, the self-criticism, the feeling, "I'm a bad person" on the one hand, and on the other hand perhaps if they're - if they've been out of the loop of their peer group as they go through school because of these feelings, they don't really have the social skills or the confidence or the communicative skills to actually establish relationships.

And certainly I've worked with people who have, when you look back, had very, very isolated lives.

And that's often maybe because they try and fail, but often it's out of choice because relationships feel too hazardous, too stressful, and it's often - really it takes a lot of work to help people get through that and start to - to form relationships and have good experiences. I suppose one other point I'd make is that the other side of it is, perhaps not with young children but children that are abused a little older or early adolescence, sexual - sexuality is like the only mode of communication they know. So they'll often carry that on and become promiscuous which, of course, doesn't let them establish good, lasting relationships. I won't say never, but, you know, it's quite hard to do that.

Other - the other side of it is many children will grow into teenagers or adults who have a deep aversion to sexuality. That will often be temporarily put into abeyance, in my experience, long enough to establish a relationship, maybe a marriage, settle into the marriage, and things start to feel stable and then they don't want to have a bar of it. They don't want to have sex. And so there's often a lot of tension and unhappiness in relationships, and maybe the person doesn't even really know where this comes from, but I think there's a lot of suffering in relationships there that comes out of these early unwanted sexual experiences.

MS RYAN: Doctor, the Board has heard evidence about the fact that some victim-survivors experience an onset of symptoms at the time of or shortly after the abuse, but for others it manifests much later and manifests in response to triggers. So can you just explain that to the Board, how that works, that is, a later manifestation and/or a flare-up at various times of someone's life in response to triggers?

DR GORDON: Or both.

MS RYAN: Or both.

DR GORDON: So - so some - some children or young people will signal that something is wrong. They'll get talked to, invited to speak, they'll speak and then they'll get some help. But what we have to think about is that sexual experience, first of all, it's happening very early on and it shouldn't be. And I think I've made the point here that very often a central feature of child development is to help them to understand that their genitals and their urine and faeces are things to be dirty, they're to be put away, cleaned up and not thought about. And so it's not until sexual sensations beginning that you can begin to understand the different set of experiences that relate to the genitals.

But before puberty, most children will make a sort of connection between sexuality and excretion. And so there's sometimes feelings of disgust attached to - instead of intimacy, attached to sexual activity. So this - those sort of conflicts will sort of - a child won't know what to do with them and if they're not having

sexual activity that will disappear. But then maybe in late adolescence or in adulthood when they become sexually active, suddenly all of this is there.

Now, the trigger idea rests on the understanding of the way we lay down experiences in trauma in this heightened arousal. To really convert experience into long-term memory, we need to process it, and I call it digest it, and convert it from raw experience to information. And when we've done that, we can say, for example, "I had a very upsetting experience last year, and I was very upset at the time". So I'm not having the emotion; I'm describing that I had an emotion which is in the past. I'm remembering it.

But if - I don't know, if I had a terrible time here and a traumatic time, and I see another building, another room with these tiles and I start having a sweating panic attack, and people come to me say, "What's the problem?" I don't know, it's those tiles, I hate those tiles. And you might have to then say, "Well, look, where have you seen those before?" you know, "I don't know" and then maybe, "At that time I went to the Commission of Inquiry and had a terrible traumatic time." And that would be the trigger because a link is being made that's not a conscious rational meaning link. It's a pure sensory emotional link that is either in the foreground and I'm having the experience again, or is shut down. And that's what happens to - we call them traumatic memories. They're not really memories; they're just experiences that have been shut down.

So this is very confusing for all concerned because once the trigger evokes some aspect of the experience, they're in it again emotionally. And they can be completely arbitrary features of the environment that - that just happen to be what the child looked at at the time, or something of that sort.

MS RYAN: And, Doctor, what might the impact be on a victim-survivor who discloses the abuse, but that disclosure is met with either disbelief or blame?

DR GORDON: Well, that's going to turn it all back on themselves. And if they're young, they'll think, "I'm wrong, I'm - I'm naughty" or something, but if they can hold their experience, then the message would have to be nobody else knows. You're on your own here. Nobody gets it. And that's - aloneness, I think, is a very great risk factor for suicidality and so as development goes on and people, instead of feeling they can connect with others and be understood and appreciated for the difficulties they've had, they're totally on their own. And people will use - quite often they'll use similar metaphors. They'll say, "I feel as though I'm from another planet", and that - that sort of undermines all sorts of things, sets them at risk for depression and - and a whole range of mental health problems.

So it becomes so important, I think, and we can't expect somebody who hasn't been abused to really understand it, unless they take trouble to listen or read stories about it or watch movies about it. So their sort of commonsense will start off, "Well, how can someone do that? I'm sure you're exaggerating" and so on. And this then takes away one of the fundamental features of development, which

is the way we have a sense of normality by comparing our experience with that of others. And that's the only way we can understand we're normal. And that sharing of experience is what is then interfered with.

MS RYAN: You've said, relevant to support services, that one of the keys is early treatment and engagement with professionals. And the ideal scenario is when a child comes home, discloses the abuse almost immediately, and gets listened to, is made to feel safe and supported, and gets appropriate treatment. Now, turning to, though, adult victim-survivors, can you - who perhaps have not had treatment or have only had some treatment, what is the best practice, in your opinion, in relation to support services for adult survivors of child sexual abuse?

DR GORDON: Well, ideally to have some kind of therapeutic relationship where they can actually go back and, in a safe place with a trusted relationship, unpack this gradually. It's very disturbing to do because they have to somehow make contact with those experiences. We want them to do that in a controlled way, and therefore it takes time. Some people will know they need help but they're very, very frightened of opening it all up, and in - perhaps for good reasons because sometimes it might evoke strong tendencies to self-harm and so on. So it's very important that all of the contextual issues that have occurred in their life as a result of this can - can be dealt with and they can start to manage all those reactive problems, you could call them, reactions.

And I'm certainly, you know, told people, "We'll deal with it when you're ready", and we deal with a whole lot of other things, and sometimes it can be a year or more before they're ready now to do it. And it comes when there - they are ready; they have their own timing if we let them. So I think one of the important factors is that we - it's very important that there's an open time frame in which that treatment can be offered, and sometimes sort of more focused, time-limited treatments will be very helpful for some aspects, will help the person move on, but they'll need to come back, often at another time. And we have to think about the - you know, the phases of an adult's life, having their own children, getting married, having their own children and so on as points where different aspects of the experience come back to be worked on. And I think, particularly for children, one of the clinical goals should be to help the child get beyond this feeling of "It's terribly painful to talk about it, I don't want to go there", to a more comfortable relationship so that as they move through various stages of their life they can revisit it more easily and work out what it means.

MS RYAN: Just touching on the evidence you've just given about the importance of having access to treatment which enables the victim-survivor to take the necessary time to do the work that you've explained, and sometimes, as you say, it takes a long time -

DR GORDON: Yes.

MS RYAN: - for them to get to the point that they're able to do that work. You've identified some challenges that, in your experience, you consider are faced in relation to accessing support services in Victoria, which tie in with that, namely consistency of treatment, cost of therapy services, in particular in terms of dealing with the public system where you might have 10 treatments under - 10 sessions under Medicare. So can you just tell the Board just on that -

DR GORDON: Yes. A lot of publicly funded agencies, because of the resource limitations and the huge constant incoming on the waiting list have to limit the amount of time they give, and therefore the models they will need to use will be often focused on particular symptoms.

But I think, in the big picture, the - it doesn't make sense as being cost effective. I know governments don't take that perspective, but for instance, people having sick leave and instability in work and - and the amount of tax that they will pay is going to be reduced if they don't really work this through. So one of the problems, I think, is models of treatment or even models of case management that look at sort of stabilising their lives and dealing with external problems rather than - than going for the core of the experience.

Having said that, not everyone wants to go there or perhaps needs to go there. So I think it's very important that focused clinical services are supported by what we could call broader psychosocial services that can assist people with some kind of case management around all the other problems they develop in their lives. And they may, for instance, need help to learn parenting skills for their own children. They may need help to make - get their marriage working, their relationship. So - and managing employment or even housing, you know, whatever other - other problems are going on in a life where there's a degree of instability and difficulty.

So we know that clinical work with people whose circumstances of life are in disarray or chaos or conflict, the clinical work doesn't really have a good frame to - to achieve its end. So I'd be really thinking that the case management approach, and I know that some of the CASAs spend quite a bit of time with their clients sort of managing - helping them manage their lives generally, and I think that's very important.

The third thing I would say, if we come back to the idea that we get a sense of normality by comparison, I think the process of developing support groups or groups where people who've had similar experiences can meet and talk, they don't have to talk about the experience but they just have to know that they're understood, and they can have a part - be part of a social network where they've got this unique experience that - that is understood is -

MS RYAN: Is that what's referred to as peer support.

DR GORDON: Yes, so we'd call that peer support networks and support groups. I think that - that we actually need the whole, not just clinical service, but a whole range of things.

MS RYAN: You've also touched on, in relation to continuity and care, the particular difficulties faced by people in regional and rural areas to access not only care but continuity of care. Can you expand on that?

DR GORDON: Yes. Well, I - I just think the - there's a big challenge in getting adequate clinical services in remote rural areas. And in my experience, although there's often a core of staff that are very dedicated and remain there for very long periods, there's often lots of other staff that come and go. And I think continuity of care is a very important therapeutic factor and having said that, of course, sexual trauma is a very challenging area to work in, and unless we build in to the - to the service strong investments in supporting the clinicians so that they have good supervision, good opportunities for debriefing and reflective practice and so on, then they tend to burn out after a while and say, "I'm going to go something different." A lot of it will be to do with the ability to learn and apply the learnings as they become more experienced, and we know that some people will do this work for many, many years and do wonderful work, but I think investment in staff support is crucial, particularly in the country.

MS RYAN: You've also stated in your witness statement the importance of victim-survivors from particular communities to have access to support which does not carry with it judgment, for example, people from the - victim-survivors from the LGBTQI community. Can you just expand on that?

DR GORDON: Well, I just think that people in - that belong to groups that are perhaps seen by some members of the community as to be criticised or they've got various opinions about it, they experience such a lot of criticism, prejudice, judgment anyway, that it creates an enormous difficulty with sexual abuse because they are already feeling these problems. So - so I think in that case, the sense of belonging to a community of people that share common experiences is crucial, and that means probably the development of those support groups, networks, sense of community is really almost a precondition for then getting treatment. And I think it's very important that the clinicians have good training in understanding the sensitivities of - of people with those experiences. Having said that, I think that the current advocacy for groups of - of all sorts is very, very important and a great benefit to the current development of services.

MS RYAN: You've also touched on the importance to encourage training of people from all diverse backgrounds and communities in provision of support services, relevant to providing support services to people from culturally diverse communities.

DR GORDON: Yes. Yes. Well, in - in dealing with this very vulnerable area, I think people are going to feel comfortable with somebody who - where they

recognise a lot of common ground. It could be cultural, it could be belief systems, it could be - it could be gender. We - we know that they aren't the whole problem. You don't necessarily have a good therapy because you've got the person - the gender you want or something like that. It's going to end up coming down to the quality of the therapy. But often to engage people, it's so important to have a range of possibilities, because for some people this will be crucial in them being able to take the first steps of trust.

So that means ensuring that we get representation of all the groups in our community into training for counselling and clinical work.

MS RYAN: And you've noted in your statement that in your experience, in a variety of areas of trauma, secondary victims often miss out on support services, and you've noted that it's - it's very important that they receive support services, and why do you say that?

DR GORDON: Because sexual abuse is an injury to the family. It's devastating for a parent to have this happen to a child. It - it's a - it's a sense of failure of my fundamental care. And so I think that's - you could say the parent is going to have the experience in a different way and therefore they need help. But by the same token, if you have one child of a group of siblings who's abused and this comes to light and there's a whole lot of treatment, maybe legal processes and so on, and the parents are going to become very focused on that child and supporting their development, it's very easy for the other children to be lost, to feel they're not as important, that their problems are not as bad and so on.

So it's - I think it's very, very important that we don't have a very narrow and rigid criterion on who is entitled to support from these various services, but to see it in - very much in terms of family, and I'd throw grandparents in there too. Many grandparents are very involved in their children's lives and are very affected. There may be - there may be aunts or there may be other people. So to have it defined by the circumstance of that particular child and their network.

MS RYAN: The Board has also heard evidence of the impact of child sexual abuse on an adult victim's partner and children. So do they also -

DR GORDON: Absolutely.

MS RYAN: - feature in that list?

DR GORDON: Because there's a kind of principle we come to understand in psychotherapy that if you have had traumatic experience in the past and you aren't able to bring them into the foreground and to go through this process I mentioned where you can put them in the past, then in some way they keep appearing in the present moment, and so you'll get highly charged anxieties about the emerging sexuality of the victim-survivors' own children, which may heighten their

sensitivity but will often make it very hard for them to have a very calm and reasonable and supportive aspect to these things. They'll tend to overreact.

And the same with partners. So in my experience, people can have a good sex life for a certain period of time, then something happens. Maybe - let's say the partner is retrenched or something, something happens to lower their self-esteem and it suddenly opens up all this self-loathing. So yes, I think it's very important to understand. It's a part of a social system.

MS RYAN: You've had extensive work, as we outlined at the beginning of your evidence, in providing psychological services and support as part of disaster response and you've had extensive experience working with communities who've been affected by trauma. What do you say in your experience would be best practice or good ideas, even, for healing in terms of a community where - the Board is dealing here with government school and the Board's considering concepts such as a memorialisation or some kind of recognition of what have - what can - what has occurred. Can you comment on that in your experience?

DR GORDON: Yes, I think it's really important. You know, what we see with bushfires is that often two or three years down the track, as people start to - you know, they've rebuilt and so on, they start to try and think, what does this mean for our community and that's when people start to gather up all the photographs and the narratives and they'll publish a book of what happened to our community. And I think these are really important history-making events. The real - socially speaking, the solution to trauma is history, because history is in the past, but it also tells us what - what we might have learnt. And then we can actually take that learning into changing society for the better.

And this is - such an important part of the healing of sexual abuse is the sense that this is coming into the open, that it's realised that this is wrong and that the community at large is against it. So it means it needs to be acknowledged and talked about. I think I might have mentioned in my evidence the case of the young woman that was being abused by a family member, and at school one day she had a social science class in which the words "incest" was used, and explained, and she suddenly realised that's what was happening to her. She had no name for it so she was able to go home that night and say to the perpetrator, "This is incest. If you ever do this again, I'll tell the police", and he never did it again.

That's empowering really. It's going against the confusion I spoke about earlier on and giving the child words and names. So as part of the community process, the community of a school, for instance, we don't do any good by brushing it under the carpet, saying it never happened, because, especially nowadays with social media, it will get out. But I think to put it in the right context. And so often the development of a memorial or a commemoration or something is a really creative task to engage the community in, the community of affected people, but also the

other people who care about the school, let's say, so that they can all work together.

And it's most important that no one thinks they have the answer, but it's the communicational task, people thinking about what happened and thinking about how we want to do this. I'm aware - it wasn't a State school - of a private school that had a historical abuse emerge, and I think the principal at the time made some very quick authoritative decisions about what would be done, but didn't really consult the - the affected people, and this led to a huge uproar and eventually the principal was replaced by somebody who, again, sent up a whole structure where the affected people and anyone else who was interested could come and they talked, and they ended up dismantling the memorial and designing something very different and - and very artistic from what I heard.

So I think it's that process that is the healing thing to - whether it be a plaque or planting a tree or whatever, it doesn't matter, that the community create that for themselves.

CHAIRPERSON: I was really struck by what you said, the words:

> "The solution to trauma is history."

Because one of the things we've heard a lot about from victim-survivors is the need to have a full understanding of what went on.

DR GORDON: Yes.

CHAIRPERSON: In order to feel that one can embark on a healing process, because if one has a narrow view perhaps about just what happened to you but you don't understand the fuller context.

DR GORDON: That's right.

CHAIRPERSON: And that that might impede the ability to properly heal.

DR GORDON: And you will find that, you know, I can think of situations I'm aware of where the sort of historical thing comes out and suddenly a group of other kids realised that they - someone attempted to groom them but they didn't - they didn't go along with it. And it didn't - chances were - they suddenly realised, "I just missed out". And this changes how they see their school experience. So it's very helpful for them, to not only be in there to support their - their peers who went through this, but to say, "Wow, wasn't I lucky, what could have happened."

So the more this is talked about and thought about, the experience can be converted into informed care of their own children and sort of a - it's a sense that we've learned from it as a society, really, ultimately.

MS RYAN: And ultimately, Doctor, it comes back to one of the themes throughout your statement about the need for public acknowledgement.

DR GORDON: Yes.

MS RYAN: At a variety of levels.

DR GORDON: Yes. That - that's - if I can just say, I think even the holding of an inquiry, the fact that the government or people in authority think it's sufficiently important to spend this much time and money on actually finding out what happened, it's enormously important I think, even though I think some of the victim-survivors would take a view of saying, well, maybe we should be - the money should be given to us. But I think for the larger picture of society, the only way it's going to enter the social consciousness at large is through proper official legal acts, such as publishing a report. So I think it's really important.

MS RYAN: Chair, I don't have anything further for Dr Gordon.

CHAIRPERSON: Thank you. Dr Gordon, thank you very much for all of the time you've given us, I know there's been a lot of work that's gone into your witness statement, and also attending today. I think we've benefitted a lot from your expertise and your experience. So thank you.

DR GORDON: Thank you very much.

<THE WITNESS WAS RELEASED

CHAIRPERSON: I'm going to adjourn until tomorrow morning at 10 am.

<THE HEARING ADJOURNED AT 3.01 PM TO FRIDAY, 24 NOVEMBER 2023 AT 10.00 AM