



Our **Mission** is to prevent child sexual assault in our society.
Our **Vision** is to make Australia the safest place in the world to raise a child.

23rd January 2020

Mental Health Inquiry
Productivity Commission
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Productivity Commission Draft Report: Mental Health

Dear Commissioners:

Bravehearts is pleased to provide this feedback to the Productivity Commission on the Draft Report on Mental Health.

As an agency that works with, and advocates for, survivors of child sexual harm, Bravehearts strongly believes that in order to properly and effectively address mental illness in our community, it is critical that we provide prevention and early intervention strategies that address the causal factors of mental health concerns and manage the potential effects of adverse childhood experiences. As an agency that is focussed on advocating for appropriate and effective responses to child sexual assault, our submission is made within this context.

We would like to recognise the immense work that has been undertaken by the Productivity Commission in preparing this extensive draft report, and note the collaborative approach undertaken. Bravehearts appreciates the opportunity to provide our feedback to this report.

Child Sexual Assault

Approximately, one in four girls and one in six boys will be sexually assaulted in some way by the age of 18. These figures have been consistently reported over the past 20 years. For background to our submission, we provide the following facts surrounding child sexual assault:

- It is estimated that 1 in 4 girls and between 1 in 7 and 1 in 12 boys are victims of sexual assault. (James, 2000)
- Research shows a staggering 45% of women aged 18-41 were sexually assaulted as children by family members (30%), friends or family friends (50%) or strangers (14%). 75% of the abuse involved some contact, most of which was shockingly severe. (Watson, B., Griffith University, Herald Sun, 9th October, 2007)
- Based on a review of research conducted on child abuse between 2000 and June 2008, researchers estimate that... between 5 and 10% of girls and up to 5% of boys are exposed to penetrative sexual assault, and up to three times this number are exposed to any type of sexual

assault. (Gilbert, Spatz-Widom, Browne, Fergusson, Webb & Janson, 2009)

A summary of Australian prevalence studies estimates that 4 - 8% of males and 7 - 12% of females experience penetrative child sexual abuse and 12 - 16% of males and 23 - 36% of females experience non-penetrative child sexual abuse. (Price-Robertson, Bromfield and Vassallo, 2010)

- An Australian birth cohort study found that at age 21 years, child sexual abuse was self-reported by 19.3% of males and 30.6% of females (Mills, Kisely, Alati, Strathearn & Najman, 2016).

We note that the costs of child sexual assault, and childhood trauma more broadly, have been estimated in several Australian studies:

- A report released by the Australian Childhood Foundation, along with Monash University and Access Economics in 2008, described two approaches to calculating costs associated with child abuse and neglect. The first, which estimated the cost incurred by the Australian community associated with children who were abused or neglected in 2007, showed that the best estimate of the actual cost of child abuse incurred in that year was \$10.7 billion, and as high as \$30.1 billion. The second, which estimated the future costs to the community which would be incurred over a lifetime for the children abused or neglected for the first time in 2007, showed that the projected cost of child abuse and neglect was \$13.7 billion, and as high as \$38.7 billion (Taylor, Moore, Pezzullo, Tucci, Goddard, & De Bortoli, 2008).
- Pegasus Economics has estimated that if the impacts of child sexual, emotional and physical abuse in Australia (on an estimated 3.7 million adults) are adequately addressed through timely and comprehensive intervention, the combined budget position of Federal, State and Territory Governments could be improved by a minimum of \$6.8 billion annually (Kezelman, Hossack, Stavropoulos & Burley, 2015).
- More recently, Deloitte Access Economics calculated the annual costs resulting from violence against children to be \$34.2 billion nationally, with an estimated national lifetime cost of \$78.4 billion (Deloitte Access Economics, 2019).

In line with these alarming figures, we note that the Commission's current Draft Report on Mental Health estimates that the conservative cost of mental health and suicide to the Australian economy is between \$43-51 billion.

The Statistics: Child Sexual Assault and Mental Health Outcomes

Child sexual assault has long been recognised to have a key relationship to later mental health outcomes. The mental health system is filled with survivors of prolonged, repeated childhood trauma.

Statistics over the years have shown:

- Young girls who are sexually assaulted are 3 times more likely to develop psychiatric disorders or alcohol and drug abuse in adulthood, than girls who are not sexually assaulted. (Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000)
- Among male survivors of child sexual assault, more than 70% seek psychological treatment for issues such as substance abuse, suicidal thoughts and attempted suicide. Males who have been sexually assaulted as children are more likely to violently victimize others. (Walrath, Ybarra, Holden, Liao, Santiago, & Leaf, 2003)
- Women with a history of child sexual assault were more likely to use mental health services, pharmacy services, primary care services and speciality care. (Bonomi, 2008)

- One study analysing seven meta-analyses on child sexual abuse and adult psychopathology found sexual abuse to be a nonspecific risk factor for a range of adverse mental health outcomes (Hillberg, Hamilton-Giachritsis & Dixon, 2011).
- Sexual abuse perpetrated by a caregiver is associated with particularly severe complex trauma symptoms into adulthood (Kluft, 2011).
- The experience of sexual abuse during childhood is a key antecedent of complex trauma symptoms. Research has shown that the symptoms of complex trauma most often result from prolonged exposure to multiple forms of interpersonal trauma (including sexual abuse), typically during childhood, by caregivers who are expected to provide a safe, predictable, and secure environment (Courtois & Ford, 2013).
- A New Zealand birth cohort study found that sexual abuse prior to age 16 was associated with a range of adverse outcomes at age 30, including depression, anxiety, PTSD symptoms, and reduced self-esteem and life satisfaction. These negative outcomes were also found to increase alongside the increasing severity of abuse experienced (Fergusson, McLeod & Horwood, 2013).
- A study of child sexual abuse, its co-occurrence with other forms of maltreatment, and mental health outcomes among males has shown that having a history of child sexual abuse only, and of child sexual abuse co-occurring with other types of maltreatment, was associated with higher odds for many mental disorders and suicide attempts compared to having a history of child maltreatment without sexual abuse (Turner, Taillieu, Cheung, & Afifi, 2017).
- Men's experience of child sexual abuse has been shown to be positively associated with depressive and somatic symptoms as well as hostility into middle and late adulthood (Easton & Kong, 2017).

A recent study published in the Medical Journal of Australia in December 2019 (Green, et.al., 2019), examined links between children subject to child protection reports in during early childhood (defined as birth to 6years) and diagnoses of mental disorders during their middle childhood (defined as 6 to 14 years). The research found that:

- Out of 74,462 children in the NSW Child Development Study, 13,796 (18.5%... almost 1 in 5) were the subject of child protection notifications in their early childhood:
 - 2,828 (3.8%) had been substantiated for significant harm or risk of significant harm: 1,148 children had been placed in out-of-home care at least once and 1,680 had been the subject of substantiated 'risk of serious harm' reports but were not placed in care
 - 1,807 had reports that did not reach the threshold for significant harm (considered to have maybe been at risk of serious harm, but not substantiated).
 - 9,161 had non-substantiated reports
- The study found that early childhood contact with child protection was associated with increased frequency of being diagnosed in middle childhood with a mental disorder and that the frequency of diagnosis was higher for children who had been placed in care.
- Findings highlight the need for strategies for detecting children at increased risk of being harmed in order to provide support to families much earlier, so that maltreatment and its damaging mental and social consequences can be averted

There is also a highly significant relationship between childhood sexual assault and various forms of mental health-related issues later in life:

- Young people who had experienced child sexual assault had a suicide rate that was 10.7 to 13.0 times the national Australian Rates. A recent study of child sexual assault victims found

32% had attempted suicide and 43% had thought about suicide. (Plunkett, Shrimpton & Parkinson, 2001)

- A school-based survey study with 2,485 South Australian early adolescents also showed that reported experience of sexual abuse was associated with suicidal ideation and suicidal behaviour (Martin, Bergen, Richardson, Roeger, & Allison, 2004).
- Rates of suicide are significantly higher among victims of child sexual abuse than comparison groups. One study found sexual abuse victims were 18 times more likely to commit suicide than those in the general population (male abuse victims 14 times more likely and female victims 40 times more likely) (Cutajar, Mullen, Ogloff, Thomas, Wells, & Spataro, 2010).
- Rates of accidental fatal overdoses are significantly higher for victims of child sexual abuse than comparison groups. Sexual abuse victims were 49 times more likely to die as a result of an accidental overdose than those in the general population (male abuse victims 38 times more likely and female victims 88 times more likely) (Cutajar et al., 2010).
- Experience of child sexual abuse has been shown to be associated with heavy drinking, hazardous drinking, and the use of marijuana and other illicit drugs – these associations have also been shown to be only marginally attenuated when controlling for depression and self-reported emotional and mental health (Tonmyr & Shields, 2017).

Productivity Commission Draft Report Key Reform Areas

Reform Area 1: Prevention and early intervention for mental health and suicide attempts

Bravehearts notes that often in discussions around prevention, governments are focussed primarily on secondary level prevention. It is our position that the only way to effectively address mental health outcomes is through a holistic approach encompassing programs targeting at all levels of prevention:

- Primary prevention: where the objective is to prevent issues from occurring through eliminating or reducing factors that impact negatively on a concerning issue and increasing factors that impact positively on a specific area of concern.
- Secondary prevention (early intervention): where the objective is early intervention through understanding and focusing on those with specific vulnerabilities or risk factors.
- Tertiary prevention: where the objective is to respond to and reduce the impact of a concerning issue targeting those affected.

As an agency that works specifically within the area of child sexual assault, we recognise the incredible importance of primary prevention and education in reducing prevalence of child sexual assault and child abuse, and subsequently the often-long term mental health and related impacts.

Services providing education and prevention around child sexual assault and personal safety are a fundamental key to achieving long-term reductions in the devastating impact of this crime on mental health statistics.

In line with this, a strong feature of the published research on personal safety programs has been the evidence that suggests that preventative strategies are far more cost effective, importantly in relation to mental health outcomes, than trying to fix the problem after the fact.

In particular we advocate for:

- Crucial resourcing of education and prevention and budgetary allocations to fund proven, effective programs that demonstrate best practice and are focused on building resilience in children.

- Screening of social and emotional development to be included in existing early childhood physical development checks to enable early identification of and early intervention.
- Teachers and school professionals to receive adequate training and professional development around child sexual assault and exploitation, child abuse and neglect, and social and emotional development.

Bravehearts addresses this through our suite of personal safety education programs that aim to empower children and young people and build confidence and resilience:

- *Ditto's Keep Safe Adventure show* for 3 to 8-year-olds currently facilitated by 7 education teams in Queensland, New South Wales, Tasmania and Victoria, with plans to grow to other states in the next 2 years. This program includes *'Ditto in a Box'* follow up resources for schools that align with the national curriculum and the respectful relationships curriculum, and adapted Ditto in a Box resources for early learning centres and kindergartens. These resources can also be used in isolation but are ideally implemented following a visit from one of our education teams and as required throughout the year.
- *Cyber Echo* currently offered online for 8 to 12-year-olds focused on online safety and respectful relationships.
- *Project You* is a respectful relationships and personal safety program for secondary school students. The current format is a full day program facilitated by Bravehearts specialist presenters. Currently in development of a digital program facilitated in the classroom by the teacher.
- Complementing our school programs are our training and professional development courses for teachers and child care workers.

Reform Area 2: Close critical gaps in health care services

Long term psychopathology of 2,759 Australian children who were sexually assaulted between the years of 1964 and 1995, were evaluated 12 to 43 years after the assault occurred (Cutajar et al. 2010). Findings revealed that 22% of individuals who had experienced child sexual assault later accessed public mental health services, in comparison to only 7% of those in the control group. The authors identified that child sexual assault increased the likelihood of experiencing psychosis, mood and anxiety disorders, substance abuse and personality disorders.

As discussed under Reform Area 2 ensuring availability, timely delivery, and appropriate services is critical in closing the gaps in the provision of mental health services. Working with victims/survivors of child sexual assault and exploitation, we are all too aware of the difficulty many face in accessing appropriate support.

Ensuring that there is specialised and effective therapeutic support for survivors of child sexual assault is essential, yet there is a recognised gap in the training of therapists (psychologists, counsellors, social workers) in the area of child sexual assault. This has been recognised in Outcome 6 of the National Framework for Protecting Australia's Children 2009-2020. Effective intervention and support can only occur if professionals working with these children are properly equipped to deal the specialised nature of this work.

As identified in the Draft Report, a well-functioning mental health response:

- is varied in line with the nature and severity experienced by an individual.
- provides and facilitated affordable, culturally appropriate, timely and available services, regardless of where an individual is.

- delivers a service that is seamless and 'joined up' regardless of how the individual first enters the system and without gaps as needs may change.

In particular we advocate for:

- Increased access to telehealth irrespective of location to encourage uptake and usage of sessions made available under Medicare, and that there is no minimum distance between the consumer and clinician stipulation
- Increased telehealth access to Psychiatrists for consultation under MBS to improve access for new clients especially private psychiatrist
- Consideration of non-Western, more culturally appropriate mental health treatments for Aboriginal and Torres Strait Islander population (for example, a cultural healer).
- The need for more trauma informed approaches within correctional facilities.
- Screening all inmates entering correction facilities and at the point of exit and linking with community agencies as part of the release process.
- Strengthening the support and training to GPs to have greater access to Psychiatrists for phone consults that they can bulk bill for.
- A greater presence of allied health professionals available more widely in GP surgery setting.
- Strengthening the CPD requirements for GPs and Psychiatrists in relation to medication and side effects.
- A specialist registration system for GPs with advanced specialist mental health training.
- Considering mental health support and treatment for older Australians.
- Increasing the number of session available to individuals to 20 sessions in a calendar year, with GP re-referral at 10 sessions to evaluate and sign off

In 2009, the Federal Government provided funding for Bravehearts to deliver our Practitioner Workshop, based on our specialist experience, across the country. The workshop is aimed at training participants to work effectively with victims, and increases both practitioner knowledge and confidence in responding to those affected by child sexual assault, with core focus on:

- Understanding the nature of child sexual assault;
- Strengthening therapeutic approaches to children affected by sexual assault;
- Effective therapeutic interventions with children who have experienced sexual assault;
- Understanding the principles behind psycho-educational tools to teach personal safety messages to children;
- Effective responses to disclosures of sexual assault within the therapeutic environment;
- Supporting parents to respond appropriately and effectively to disclosures, as well as behaviours and emotions often associated with child sexual assault;
- Understanding the toll on the therapist when working in the area of child sexual assault and identifying key self-care and organisational-care strategies to minimise this effect.

Since 2009, Bravehearts has continued to provide this specialist training, most recently running a three-day training workshop from our Head Office in Queensland in June 2019. The uptake of these training opportunities exceeded any expectation and it is clear that specialised training in this area is desperately needed. Bravehearts believes that it is critical that monies are set aside for specialist training, to ensure that there is an adequately trained mental health workforce to provide the critical therapeutic support for children and young people affected by sexual harm and to ultimately reduce the long-term mental health outcomes and costs.

Reform Area 3: Investment in services beyond health

Reform Area 4: Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

Bravehearts acknowledges that there is a critical need to ensure investment in, and accessibility to, services for those people with mental illness, beyond therapeutic support; including, but not limited to psychosocial, legal and justice, housing (including, programs to support those with mental health illness in the community rather than hospital settings), education, and employment.

The long-term impacts of child sexual assault affecting adult survivors are well researched and documented. Individuals with a history of child sexual assault are at an increased risk for not just mental illness, but many other impacts, including, but not limited to:

- substance abuse
- homelessness
- suicidality
- revictimisation, including domestic violence and sexual assault
- exposure to the criminal justice system
- parenting difficulties, and
- physical health issues.

As noted in the Draft Report, services outside of the mental health system are often not set up to respond or be delivered in ways that effectively address the needs of individuals with mental health issues.

In particular we advocate for:

- Investment in stable, appropriate housing.
- Support to ensure accessibility to services and programs to meet the varied needs of those with a mental illness.
- Support for those seeking to reconnect or continue with education.
- Placement and support programs to assist people reconnect with workplaces.
- That mental health be explicitly included in workplace health and safety; with codes of practice developed and implemented.

Reform Area 5: Fundamental reform to care coordination, governance and funding arrangements

One of the most crucial avenues to increasing the effectiveness of mental health responses is for a better engagement in a 'multi-disciplinary and multi-agency approach', both within government and with external agencies. This coordinating and collaborative approach assists with ensuring clear pathways for individuals entering into and navigating the complex mental health system.

We note that both the Commonwealth and the States and Territories have responsibilities for different aspects of the mental health system, with the Commonwealth focused on primary mental health care and States/Territories responsible for acute mental health care. As identified in the Draft Report this leaves a 'grey' middle where the two may intersect (for example, where an individual moves from one system to another, or where someone may receive care from multiple providers).

Reforming how the different levels of government work together and clearly defining the roles and responsibility will undoubtedly assist with accountability, transparency, coordinating funding, and a clearer pathway for service provision for people experiencing mental health issues.

Underpinning all of this, Bravehearts believes that it is absolutely critical that a program of “evaluation should inform the allocation of public funds across the mental health system to ensure that they are deployed most efficiently and effectively”.

We fully support the recommendations to evaluate the efficacy of: MBS psychological therapy (for both face to face and telehealth); the currently funded Mental Health Support Line; and the PHNs to determine if this is the best application of funding.

In particular we advocate for:

- Coordinating primary and mental health care provision and services.
- Funding be directed to the best and most suitable services for the population with the service catchment area.
- Promoting a culture of ongoing service evaluation to ensure that the needs of clients, communities are being met and that services are being run efficiently and effectively, and providing support that is evidence-based.

We thank the Commissioners for the opportunity to provide this feedback and hope that the information provided will be considered in the final report. Please contact us on 07 5552 3000 or research@bravehearts.org.au if any further information is required.

Kind Regards,

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