Child Abuse - Mental Health

This submission underlines the often substantial mental health needs of survivors of childhood abuse. Despite comprising a large percentage of the Australian community, many survivors are severely disadvantaged and from a repeatedly marginalised sector whose complex needs have been largely ignored by governments. ASCA is the only national organisation which offers a comprehensive set of services to this sector. However ASCA receives no recurrent funding, either federal or state.

Many of the insidious social ills our community faces are a direct result of the unhealed trauma of childhood abuse. Until we recognise the root causes of abuse, address them within the family, institutions and general community, assist individuals to address their abuse issues and make changes to break the cycle of abuse from one generation to the next, society will continue to flail under burgeoning rates of mental and physical ill health, addictive disorders, criminality, family breakdown, unemployment and homelessness.

While the impact of abuse is often all too apparent, it is also important to note that a large number of people are affected by abuse-related issue in more subtle ways. Many survivors simply do not reach their potential or live a life of detachment and disconnection.

Child abuse and neglect is Australia's most serious social problem (NAPCAN). The Senate Committee Report 'Protecting Vulnerable Children- A National Challenge (Mar 2005) had as its first recommendation the designation of a year as the National Year Against Child Abuse in Australia. Although this recommendation has not been adopted ASCA is pleased to see that a summit is being called early in 2006.

In the last reporting year a child was substantiated to have been abused and/or neglected every 13 minutes – more than 40,000 children in total and given the secret nature of this crime, true figures are undoubtedly much higher (AIHW). These child victims become adult survivors. As a society it is our responsibility to not only look after them but also to ensure that their legacy does not become that of future generations. The impact of child abuse is long-lasting, both for individuals and society; services need to be sustainable and funding for service provision, recurrent. **Tackling child abuse not only requires early intervention and child protection programs but focussed and collaborative programs of support and mental health care for survivors**.

A human rights issue…

Everyone has the right to a standard of living adequate for the health and well-being of himself and of the family, including food, clothing, housing and medical care and necessary social services, and the right for security in the event of unemployment, sickness, disability, widowhood, or other lack of livelihood in circumstances beyond his control. ***Universal Declaration of Human Rights, Article 25(1)***

Child victims not only endure repeated abuse, neglect and torture as children but adult victims are often repeatedly re-abused within a society which fails to acknowledge their fundamental rights and needs.

The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (*International Covenant on Economic Social and Cultural rights, Article 12*)

Abuse survivors experience a range of profoundly debilitating chronic physical and mental health issues and these are not being adequately addressed in our society.

A mental health issue…

In the mental health arena, research has shown childhood sexual abuse (CSA) to be associated with depression,[i] anxiety disorders,[ii] poor self-esteem,[iii] aggressive behaviour,[iv] suicide attempts,[v] eating disorders,[vi] use of hard drugs,[vii] and alcohol abuse.[viii] These kinds of problems are not only related to sexual abuse; all forms of child abuse have long-term negative effects.[ix]

Statistics vary. However the prevalence of childhood sexual abuse is estimated to be 1 in 3 women, and 1 in 6 men.[x] Sexual abuse accounts for less than 25% of all reports of abuse and neglect to child protection authorities.[xi] With the incidence of substantiated cases of abuse having doubled over the last 10 years, child abuse issues and their impact need to be actively addressed.

Survivors experience a wide range of emotional and mental health needs, related physical health issues and frequently utilise a variety of health and mental health services.[xi] Practitioners need to be trained to be sensitive and responsive to complex needs such as the compounding problems of mental illness and substance abuse exacerbated by socio-economic factors. Until clients are able to access appropriate services, are provided with relevant information, and have an opportunity to discuss their health concerns with a practitioner or participate in counselling or therapy they cannot begin the recovery process.[xii] The Burdekin Report 1993 called for counselling for women who have experienced all forms of sexual assault and violence.

ASCA asserts that all survivors of all forms of abuse, female and male, deserve access to counselling (one-to-one), intensive specifically-developed therapeutic programs or group therapy (either self-help or counselor-facilitated)… Survivors frequently find a therapeutic setting in which group members are able to share traumatic material within the safety, cohesion, and empathy provided by other victim / survivors invaluable. *"As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past."* [xiv]

While ASCA has the expertise to offer these options, it does not have the funds. Many of these services are inaccessible to those needing them for economic, social or service delivery reasons.

Child Abuse needs to be acknowledged as a prominent mental illness issue. Shrouded in secrecy, battling stigma and shame, survivors are doubly disadvantaged and often face discrimination which compounds their existing problems. Only by addressing survivors' mental health issues will society maximise returns to full social and economic participation. However, diagnostic labelling of mental ills can also limit treatment – ideal is an appreciation of the range of issues with which survivors battle.

Mental Health Issues for Child Abuse Survivors - The Facts

- CSA is linked with higher rates in adults of **depressive symptoms, anxiety symptoms, substance abuse disorders, eating disorders and post-traumatic stress disorders** (Briere & Runtz: 1988; Winfield et al.: 1990; Bushnell et al., 1992; Mullen et al., 1993; Romans et al., 1995:1997; Fergusson et al.: 1996; Silverman et al.: 1996; Fleming et al. in press). A more controversial study links multiple personality disorder with CSA (Bucky & Dallenberg: 1992; Spanos: 1996).[xv]
- **"Abusive acts thereby serve as an etiologic reservoir for the development of later psychological disorder," (Briere: 2002).[xvi] Survivors often experience conflictual relationships, chaotic lifestyles and frequently report difficulties forming adult intimate attachments.[xvii]**
- **Studies have documented the close connection between the severity of CSA and the degree to which survivors experience dissociative states.[xviii]**
- **Suicidality** In one community study, 16% of survivors had attempted suicide compared to 6% of their non-abused cohorts.[xix]
- **Self-mutilation** is frequently described among former victim / survivors.[xx]
- Several studies connect CSA with **alcohol and substance abuse** in adolescents and adults. Briere and Runz (1990)[xxi] found that, compared to non-abused female clients, sexually abused females in crisis centres

were four times more likely to have a history of substance abuse and twice as likely to be alcoholic.[xxii]

- In a study of pathways *between* **drugs and crime, drug abuse** consistently pointed to histories of sexual, physical and / or emotional abuse. Research showed that, *"eighty-seven per cent of incarcerated women were victims of sexual, physical or emotional abuse in either childhood (63 %) or adulthood (78 %). The majority were victims of multiple forms of abuse; childhood and adult abuse were correlated with drug dependency and involvement in the sex trade..."* (Johnson, 2004: xiv)[xxiii]
- A large-scale study in the USA suggests that CSA and sexual assault may be more likely to lead to **PTSD** (Post Traumatic Stress Disorder) than other types of traumatic events. This percentage was significantly higher than the 38.8% rate of PTSD percentage of men who had experienced combat.[xxiv]
- There is frequent co-occurrence of CSA, neglect, physical abuse, emotional abuse, and exposure to domestic chaos in families of clients with **BPD**.[xxv] (Borderline Personality Disorder)
- A sample of neglected, physically abused, and sexually abused 8-12 year old children were found to have very high levels of **depressive symptomotology**.[xxvi]
- **Eating disorders - Individual risk factors for eating disorders include dysfunctional family and social systems, obsessive-compulsive disorder, preceding depressive disorders, BPD and a previous history of sexual abuse.** [xxvii] [xxviii]
- **Abusive behaviours and assault, whether physical, sexual or psychological can create long-term interpersonal difficulties, distorted thinking patterns and emotional distress.**
- **Abused children indiscriminately seek the affections of someone to depend on, often from the very parents who are their abusers. This fragmentation becomes central to personality organisation, preventing integration of knowledge, memory, emotional states and bodily experience. Survivors often maintain this pattern into adulthood relationships with abusive partners.**
- **In an environment of childhood abuse the child-like propensity towards self-blame and lack of worth are reinforced.**
- **Frequently feelings of rage and aggressive behaviour, normal reactions to abuse, manifest during childhood and are expressed in adulthood by an inability to resolve conflict and an inability to modulate anger**
- **It is now well acknowledged that the predictive factors of emotional and social well-being are diverse indeed…….In fact, many risk factors are complex, and obtain from the circumstances of our everyday lives – material well-being, education, community inclusion and acceptance, employment opportunities, social cohesion and , perhaps most importantly, housing and accommodation.** [xxix]

Survivors are often isolated, financially disadvantaged and ostracised. Australian society is already experiencing… an increasingly numerous underclass with entrenched inter-generational deprivation and lack of social progress; an increasingly marginalised, disempowered subset of the community… this group is increasingly able to interact only with each other.. the greatest cost to us as a broad community, is the untapped potential of these children and adults who are trapped in an environment where their talents, skills and abilities will not see the light of day except through exceptional effort and struggle. [xxx]

Complex needs – adult and youth homelessness

Youth homelessness in Australia has doubled since 1991. The National Homelessness Strategy (2000)[xxxi] highlighted CSA, sexual and physical abuse, mental illness and substance abuse as risk factors for homelessness. [xxxii] Abuse is the primary factor causing young people to seek safety by leaving home**.**[xxxiii] **It is well documented that having become homeless, young people are at risk of becoming victims of further abuse**.

The "Living Rough Report" (1999) identified that during a 12 month period 52% of homeless youth had been sexually assaulted.[xxxiv] **Salvation Army estimates that at least 50% of the homeless young people currently being assisted by them have suffered physical or sexual abuse. In "No Place That's Home, 45% of homeless young people cited sexual or physical abuse of themselves as critical reasons why they had become homeless."** [xxxv]

Likewise, a survey conducted by Macquarie University **amongst Sydney's homeless children revealed very high levels of physical and sexual abuse**, particularly for young females. Of the girls interviewed, 73% reported physical abuse, 82% had been sexually abused, the abuse mostly having occurred under the age of 11 (67%), with 26% experiencing their first sexual abuse between the ages of 12 and 15 years.[xxxvi]

Isolated, dealing with the effects of childhood trauma, these young people experience a complexity of problems exacerbated by homelessness. Frequently seen in youth accommodation services, are **excessive use of alcohol and other drugs, self-harm, anger, depression, suicidal ideation and 'challenging behaviours'.**

Service Provision - recommendations

1. **Access and Equity** -Those within the mental health system experience barriers to access and equity – child abuse survivors experience an additional set of barriers.

    - The *National Standards of Practice Manual* (1998) state that: *"Access implies recognising cultural diversity, and **identifying and addressing barriers and structural disadvantages experienced by members of the community**."* [xxxvii] **Access also requires that no barriers exist to psychological access,** such as associated stigma or inappropriate values or philosophy of management. [xxxviii]
    - The *National Standards of Practice Manual* (1998) state as a principle that: *"Equity implies the fair treatment of all service users, a just allocation of resources and **positive discrimination towards those facing additional barriers to services**."* [xxxix]

1. **Availability** - Child abuse survivors frequently either do not have **access** to/or cannot afford the services they need and this is exacerbated in **rural, regional and remote areas**.
2. Mental health services traditionally provide preferentially for crisis intervention whereas child abuse survivors usually require **long-term multi-faceted support**
3. Most survivors cannot afford **long-term therapy/counselling** as their disability often means ongoing **financial hardship**.
4. Subsidised counselling is rare; services with limited resources cannot meet the demand and prioritise services to assist those in crisis [xl]
5. Subsidised services under health funds rarely offer more that 6 or 8 sessions with a psychologist. This can lead to **re-traumatisation**, if once material is exposed, treatment ceases due to lack of resources. It is inappropriate to engage with a client and then be unable to offer them the long-term support they need as this could be perceived as *another* rejection or result in feelings of abandonment.[xli]
6. Survivors benefit from **support groups** in which they can develop trusting relationships with others survivors, break their feelings of isolation and find validation for their experiences
7. Survivors consistently pinpoint a number of inadequacies in current service provision: difficulties in finding expert, long-term, affordable counselling; a lack of support groups and workshops; being referred to a service that only was able to offer a few sessions or telephone counselling; insensitivity or **ignorance within generalist health services and inadequate training and responses from a wide spectrum of specialist services**, such as drug and alcohol and mental health services.[xlii]
8. Survivors have complex needs, many of which need the attention of experts trained in the field of **trauma and programs specifically designed to address those needs**

9. **Consumer Participation - Survivors provide unique understanding due to their lived experience and acknowledging this is paramount to empowering them to contribute to service delivery planning, education and training, evaluation and involvement in improving quality outcomes.**
10. **Partnerships - The considerable evidence that exists associating child abuse with mental health issues, problems surrounding access and equity, and the negative experiences of survivors in their interactions with mental health services provides compelling justification for the formation of stronger links between mental health services and the NGO sector offering a wide diversity of community based services.**

- The area of domestic violence and sexual assault presents an opportunity to hypothesise - Warshaw and Moroney (2002) suggest that treatment models need to find ways of integrating service responses that reflect social and advocacy requirements as well as the psychological needs, and that issues surrounding current as well as past abuse are addressed.[xliii]

11. Research has also identified evidence-based best practice for adult survivors offers a range of flexible services from a **holistic** perspective. Provision of these services must be delivered with **dignity, care, respect, compassion and empathy**. **NGO community based services** play a crucial role in responding to the needs of survivors experiencing difficulties in accessing the myriad of government welfare services. *"Responses should be guided by coordination of effort, common sense and compassion."* [xliv]
12. Properly resourced community based services which provide **social and emotional supports, peer support and advocacy - such as ASCA -** can help return survivors the humanity, dignity and self-respect which was stolen from them as children. This needs to be offered hand-in-hand with professional services – ongoing counselling/therapy, purpose-developed programs in which individuals can pursue a personal journey within the safety of a survivors' group.
13. **Coordination of health, welfare and related community services** (including provision of relevant education and workplace training)is imperative to address the complexity of issues that arise as a result of childhood abuse. Survivors can potentially benefit from a broad spectrum of support/services including government and NGOs - DoCS or equivalent; family/community support; legal centres; drug and alcohol agencies as well as from Health Care professionals but they need to work cooperatively.

ASCA has the infrastructure and expertise to meet many of the above recommendations. As a survivor-based organization, we have the insight ahd skills to provide the support and validation our marginalized group needs. In addition we are aware of the need to utilise the expertise within our organization and outside so that we can better meet the complex needs of our members. Currently these are primarily health

professionals but stronger partnerships are needed within the professional community and with goverments and other NGO's as well. Only then will we be able to provide the holistic care needed.

Child abuse is a severe form of trauma and as such causes profound mental health repercussions. Only now are governments beginning to address the inequities in mental health provisioning; acknowledging the long-term needs of those affected. Survivors of the trauma of child abuse have been ignored and forgotten for too long already.

Without recurrent funding from federal and state governments ASCA cannot begin to provide the level of services required or reach even a small percentage of our target population. It is time for governments to acknowledge the scale, the social, mental and economic repercussions of child abuse. The focus has been on the need for early intervention and child protection. Funding is in place in these areas and quite rightly so. However it should not be to the exclusion of survivors; without appropriately addressing survivors' needs, the cycle of abuse and neglect will continue unabated.

Prepared and submitted on behalf of ASCA by Dr. Cathy Kezelman, chairperson
ckezelman@asca.org.au 0425 812 197

indnotes.

Silverman, A.B., Reinherz, H.Z., and Giaconia, R.M. (1996). The long-term sequelae of child and adolescent abuse: a longitudinal community study. Child Abuse & Neglect 20, 709-723.

[ii] Lynskey, M.T. and Fergusson, D.M. (1997). Factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. Child Abuse & Neglect 21, 1177-1190.

[iii] Oates, R.K., O'Toole, B.I., Lynch, D.L., Stern, A. and Cooney, G. (1994). Stability and change in outcomes for sexually abused children. J.Am.Acad. Child Adolesc.Psychiatry 33, 945-953.

[iv] Silverman et al, op.cit.

[v] Riggs, S., Alario, A.J., and McHorney, C. (1990). Health risk behaviours and attempted suicide in adolescents who report prior maltreatment. J.Pediatr. 116, 815-821.

[vi] Moyer, D.M., DiPietro, L., Berkowitz, R.I., and Stunkard, A.J., (1997). Childhood sexual abuse and precursors of binge eating in an adolescent female population. Int. J Eat. Disord. 21, 23-30.

[vii] Johnsen, L.W. and Harlow, L.L. (1996) Childhood sexual abuse linked with adult substance use, victimization, and AIDS-risk. AIDS Education & Prevention 8, 44-57.

[viii] Wilsnack, S.C., Vogeltanz, N.D., Klassen, A.D. and Harris, T.R. (1997). Childhood sexual abuse and women's substance abuse: national survey findings. J Stud. Alcohol 58, 264-271.
[ix] Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., and Herbison, G.P. (1996). The long-term impact of the physical, emotional and sexual abuse of children: a community study. Child Abuse and Neglect 20, 7-21.
[x] Fergusson, D.M. & Mullen, P.E. (1999). Childhood Sexual Abuse: An Evidence Based Perspective, (Vol 40). Developmental Clinical Psychology and Psychiatry, Sage Publications.
[xi]. Broadbent A and Bentley R, Child Abuse and Neglect, Australia, 1995-96 (Canberra: Australian

Institute of Health and Welfare, 1997) p. 15.
xii

NCOSS. (2004). Better social results for NSW. Social and economic priorities for a fair and sustainable community: 2005 – 2006 State Budget. .Council Of Social Services NSW, p. 69.
[xiii] NCOSS. (2004). Better social results for NSW. Social and economic priorities for a fair and sustainable community: 2005 – 2006 State Budget. Council Of Social Services NSW, p. 69.
[xiv] Fleming, J., Mullen, P. E., Sibthorpe, B., Bammer, G. The long term impact of child sexual abuse in Australian women. Australia: Child Abuse and Neglect.
O' Hanlon, B. (2005). Moving On: New, Brief, Effective (and Controversial) Trauma Treatments. Available: http://www.writtenword.com.
au/writtenword/Article.asp?Id=9

[xv] Briere, J. and Runtz, M. (1990). Differential adult symptomatologies associated with three types of child abuse histories. Child Abuse and Neglect (Vol:14) pp. 357 - 364. Winfield, I., George, L. K., Swartz, M. and Blazer, D. G. (1990). Sexual assault and psychiatric disorders among a community sample of women. American Journal of Psychiatry(Vol:147) pp. 335 - 341. Bushnell, J. A., Wells, J. E. and Oakley-Browne, M. (1992). Long-term effects of intrafamilial sexual abuse in childhood. Acta Psychiatrica Scandinavica. (Vol: 85) pp. 136 - 142. Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E. and Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. British Journal of Psychiatry (Vol:63). pp. 721 - 732. Romans, S. E., Martin, J. L., Anderson, J. C., Herbison, G. P., and Mullen, P. E. (1995). Sexual abuse in childhood and deliberate self harm. American Journal of Psychiatry (Vol:152) pp. 1336 - 1342. Romans, S. E., Martin, J. and Mullen, P. E. (1997). Childhood sexual abuse and later psychological problems: neither necessary, sufficient nor acting along. Criminal Behaviour and Mental Health (Vol:7) pp. 327 - 338. Fergusson, D. M., Horwood, L. J. and Lynskey M. T. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood: Part II: Psychiatric outcomes of sexual abuse. Journal of the American Academy of Child and Adolescent Psychiatry. (Vol:35) pp. 1365 – 1374. Silverman, A. B., Reinherz, H. Z. and Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: a longitudinal community study. Child Abuse and Neglect (Vol:20) pp. 709 - 723. Bucky, S. J. and Dallenberg, C.(1992). The relationship between training of mental health professionals and the reporting of ritual abuse and multiple personality disorder symptomatology. Journal of Psychology and Theology (Vol:20) pp. 233 - 238. Spanos, N. P. (1996). Multiple Identities and False Memories: A Sociocognitive Perspective. American Psychological Association:Washington, DC. IN: Mullen, P. E. and Fleming, J. (1998). Long-term Effects of Child Sexual Abuse. Child Abuse Prevention. (9) Autumm. National Child protection Clearing House.

[xvi] Briere, J. (2002).Treating Adult Survivors of severe childhood abuse and neglect: Further development of an integrative model. In Myers, J.E.B., Berliner, L. Briere, J, Hendrix, C.T., Reid, T. & Jenny, C. (Eds.) (2002). The APSAC handbook on child maltreatment, 2nd Edition. Newbury Park, CA: Sage Publications.

xvii

Collins, N.L., & Read, S.J. (1990). Adult attachment, working models, and relationship quality in dating couples. Journal of Personality and Social Psychology, 58, 644-663.

[xviii] Herman, J.L., Perry, J.C & van de Kolk (1989). Childhood Trauma in Borderline Personality Disorder. American Journal of Psychiatry, (146) pp. 490 – 495. Sanders, B. McRoberts, G. & Toffefson. (1989) Childhood Stress and Dissociation in a College Population. Dissociation 2, pp. 17 – 23. Chu, J. A. Dill, D.L. (1990). Dissociative Symptoms in Relation to Childhood Physical and Sexual Abuse. American Journal of Psychiatry (147) pp. 887 – 892. Sanders, B. Giolas, M. (1991). Dissociation and Childhood Trauma in Psychologically Disturbed Adolescents. American Journal of Psychiatry (148) pp. 50-54.

[xix] Saunders, B. E., Villeponteaux. L. A., Lipovsky, J. A. et al. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. Journal of Interpersonal Violence. (7). pp.189-204.
[xx] Lindberg, F. H. and Distad, L. J. (1985). Posttraumatic stress disorders in women who experienced childhood incest. Child Abuse and Neglect. (9) pp. 329-334.
[xxi] Briere, J. and Runtz, M. (1990). Differential adult symptomatologies associated with three types of child abuse histories. Child Abuse and Neglect (Vol:14) pp. 357 - 364.
[xxii] Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane. Available:
http://auseinet.flinders.edu.au/resources/auseinet/workshops/csapre51.php
[xxiii] **Johnson, H. (2004). Drugs and crime: a study of incarcerated female offenders. Research and public policy series, no. 63. Canberra: Australian Institute of Criminology. Available: http://www.aic.gov.au/publications/rpp/63/references.html**
[xxiv] Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. USA: Archives of General Psychiatry, 52, 1048-1060.
[xxv] Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane. Available:
http://auseinet.flinders.edu.au/resources/auseinet/workshops/csapre51.php
[xxvi] Toth , S. and Cicchetti, D. (1996). Patterns of relatedness, depressive symptomatology, and perceived competence in maltreated children. Journal of Consulting and Clinical Psychology, 64: 32-41.
[xxvii] American Psychiatric Association. (1993). Practice guidelines for eating disorders. American Journal of Psychiatry,150: 207-228. Powers, P.S. (1996). Initial assessment and early treatment options for anorexia nervosa and bulimia nervosa. Clinical Psychiatry America, 19: 639-656.Vitousek,K. Manke, F. (1994). Personality variables and diagnoses in anorexia nervosa and bulimia nervosa. Journal of Abnormal Psychology, 103: 137-148.
[xxviii] Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane. Online. Available: http://auseinet.flinders.edu.au/resources/auseinet/workshops/csapre51.php
[xxix] Lindsay Irons, Office of the Public Advocate, ‘Mental Health in Queensland Today’, Speech delivered at the Public Advocate’s Mental Health Forum, Brisbane 01 June 2004,page 3
[xxx] Submission 160 p 7 (Mofflyn) Community Affairs References committee: Protecting Vulnerable Children: a National Challenge
[xxxi] Commonwealth Government of Australia. (2000). Department of Family & Community Affairs. National Homelessness Strategy - A Discussion Paper. Available: http://www.facs.gov.au/internet/facsinternet.nsf/AboutFaCS/Programs/house-homelessnessstrategy.htm
[xxxii] Australian Bureau of Statistics. (2003). Australian Social Trends : Housing and Homelessness.Available:
www.abs.gov.au/Ausstats/abs@.nsf/0/ddc8dc3787e2d9fcca256e9e0028f91e?OpenDocument
[xxxiii] Tully, D. (2003) Childhood Sexual Assault and Homelessness. Paper presented at the 3rd National Conference ‘Beyond the Divide’ convened by the Australian Federation of Homelessness Organisations. April 2003.

[xxxiv] Strategic Partners Pty Ltd.(1999) Living Rough Report: Preventing Crime and Victimisation Among Homeless Young People. Report to National Crime Prevention, Attorney General's Department.
[xxxv] Smith, J. (1995). Being Young & Homeless. Analysis and discussion of young people's experiences of homelessness, The Salvation Army Youth Homelessness Research Project. Australia. Available: http://www.salvos.org.au/SALVOS/NEW/me.get?SITE.sectionshow&FFFF446#reasons
[xxxvi] Howard, J. (1991). Dulling the Pain: Two Surveys of Sydney Street Youth. Paper presented to the 9th National Behavioural Medicine Conference. The University of Sydney.
[xxxvii] NASASV. (1998). National Standards of Practice Manual: for services against sexual violence. Centre Against Sexual Assault (CASA), Royal Women's Hospital, Women's & Children's Health Care Network : Vic, Australia. Permission to Cite.
[xxxviii] Weeks, W. (2001).Access and Equity in Services against Sexual Violence. Paper presented at the Seeking Solutions Conference, Gold Coast. September : 2001.
[xxxix] NASASV. (1998). National Standards of Practice Manual: for services against sexual violence. Centre Against Sexual Assault (CASA), Royal Women's Hospital, Women's & Children's Health Care Network : Vic, Australia. Permission to Cite.
[xl] Keel, M., Fergus, L. and Heenan, M. (2005). Home Truths: A Conference in Review.

ACSSA Issues (3) March 2005.
[xli] ACSSA . (2005). ACSSA talks to Sandra Basham of the Incest Survivors Association. Australia: ACSSA Newsletter (8) June 2005.
[xlii] WISN. (1996). A Submission to the Royal Commission into NSW Police Service Paedophile Segment. The Women Incest Survivors Network Inc.
[xliii] Warhshaw,C. & Moroney,G. (2002). Mental health and domestic violence collaborative initiatives, service models and curriculum. Working Paper: Chicago. Available: http://www.dvmhpi.org/
[xliv] Raphael, B. Prof. & Newman, L. Dr. (2000) Disaster Mental Health Notebook. NSW Heath. Centre for Mental Health & NSW Institute of Psychiatry.

Advocates for Survivors of Child Abuse

ASCA, PO Box 141 Charlestown NSW 2290

Ph: 02 4965 7126; Fax: 02 4965 7359; Email: admin@asca.org.au

www.asca.org.au

Patron: Professor Freda Briggs

Donations to ASCA of $2 and over are tax deductible.