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mhcc
mental health coordinating council

PO Box 668 Rozelle NSW 2039

T 02 9555 8388
F 02 9810 8145
E info@mhcc.com.au
W www.mhcc.org.au

ABN 59 279 168 647

Sentencing Council
NSW Attorney General and Justice

E: sentencingcouncil@adg.nsw.gov.au

Subject: Standard Minimum Non-Parole Periods: consultation paper by the NSW Sentencing Council (priority submission on SNPPs for child sexual assault offence)

Dear Sirs,

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs) in NSW. Our members provide a range of psychosocial and clinical services, support programs including advocacy, education, training and information services with a focus on recovery-orientated practice. MHCC's membership consists of over 200 organisations whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health conditions. We work in partnership with both State and Commonwealth Governments to foster recovery and social inclusion for people affected by mental illness, participate extensively in policy and sector development and facilitate linkages between government, community and private sectors in order to affect systemic change. MHCC also manage and conduct research projects and develop collaborative projects on behalf of the sector. MHCC is also a registered training organisation (MHCC Learning and Development) delivering nationally accredited mental health training and professional development to the workforce.

MHCC is also a founding member of Community Mental Health Australia (CMHA) the alliance of all eight State and territory community sector mental health (MH) peak bodies. CMHA was established in 2007 in recognition of the shared activities, challenges and potential to effect change of the state and territory community sector mental health peak bodies and their respective memberships of more than 800 non-government community managed organisations (NGOs/CMOs) nationally. The primary goals of CMHA is to build a viable and sustainable community managed mental health sector and to promote the value and outcomes delivered by community managed mental health services based on a philosophy of recovery and social inclusion.

MHCC thanks the Sentencing Council for providing us with the opportunity to comment on the Consultation Paper, and we congratulate them on initiating this important inquiry.

MHCC wish to make a few comments in relation to the particular questions that focus on child sexual assault offences. First, we address the question following:

> **Suggested criteria for identifying SNPP offences**
> **Maximum penalty**
> **Question 2.2 - If the maximum penalty for an offence were to be a criterion for assessing whether an offence should be an SNPP offence, how should it be used?**

There are a number of offences that are not currently SNPP offences that carry maximum penalties of life imprisonment, 25, 24 or 20 years imprisonment. However, there are large number of offences carrying terms of imprisonment of between 15 and 20 years, and the Law Reform Commission (LRC) identified a number of these as being "serious" offences. Included in this category is: "Adult procures child, or meets child following grooming, under the age of 14 years for unlawful sexual activity (Maximum penalty: 15 years' imprisonment)".

We would argue that multiple impacts of child sexual assault on an individual are generally life-long, and that many victims experience ongoing abuse over long-periods of time, but that single child sexual assault events should not necessarily be identified as less traumatic than chronic and persistent ongoing abuse. What needs to be considered is made evident by the plethora of international and Australian literature.

We present the following evidence from our recent position paper, Mental Health Coordinating Council (MHCC) 2013, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia - a National Strategic Direction,* Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J., Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA) which includes some evidence from the literature.

> Characteristically, survivors of childhood abuse exhibit early onset of mental health difficulties and a tendency towards chronicity, lowered self-esteem and sense of hopelessness (Henderson & Brown, 1988; Harris, 1988; Romans et al., 1992).[i] Many traumatised people adopt extreme coping strategies in order to manage anxiety and overwhelming emotional distress including: suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, and dissociation. Many coping strategies become risk factors for later physical health issues.
>
> A 2007 Australian University-initiated study of over 21 thousand older Australians found child abuse survivors are almost two and a half times as likely to have poor mental health outcomes, four times more likely to be unhappy even in much later life and more likely to have poor physical health.[ii]
>
> The same study found that physical and sexual abuse increases the risk of having three or more medical diseases, including cardiovascular events in women, and in social and lifestyle aspects, a higher prevalence of broken relationships and an increased likelihood of smoking, substance abuse, and physical inactivity.

Mental health impacts

No single diagnostic term has been agreed upon internationally which captures the complexity of presentations related to the complex trauma arising from child abuse.

Seventy-six per cent of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have three or more psychiatric disorders. [iii]

Victims of abuse often carry a number of mental health diagnoses concurrently including: post-traumatic stress disorder (PTSD), borderline personality disorder, schizophrenia, depression or other affective disorders, anxiety disorder, psychotic and dissociative disorders, somatoform disorder, and sexual impairment disorders. The effects of childhood trauma are wide-ranging, and people with trauma histories frequently present with multiple coexisting conditions and problems including: substance abuse, eating disorders, self-harming behaviours, and suicidality frequently have interactions with the criminal justice system, and/or experience homelessness. [iv]

Child sexual assault is associated with two and a half times the rates of mental disorder, including being two to three times more likely to have an anxiety, mood or eating disorder; four times more likely to attempt suicide and sixteen times more likely to have a sleep disorder.

Trauma survivors may experience symptoms of Complex PTSD including intrusive re-experiencing of the trauma in nightmares or flashbacks, inability to recall part of the trauma and emotional numbing as well as hyper-arousal.

As previously noted, many survivors carry a diagnosis of Borderline Personality Disorder (BPD). BPD is one of a group of 'personality disorders' listed in the DSM 5 (2013) and characterised by ‘significant self and interpersonal functioning impairments’; distressing emotional states with a set of symptoms including; difficulty in empathising and relating to other people; aggression; poor impulse control, suicidality and self-harming behaviours such as substance abuse, eating disorders, cutting and self-mutilation . Some researchers have estimated that up to 75% of individuals diagnosed with BPD have experienced sexual abuse in childhood (Linehan, 1993).[v]

Dissociation is a set of trauma-related phenomena ranging from altered awareness and out of body experiences, to a lack of integration of information within the cognitive system. People experiencing dissociation can present with vagueness; excessive daydreaming; de-personalisation; de-realisation; disengagement from the immediate environment; altered body perception; emotional numbing; amnesia for traumatic experiences; and at the extreme end of the spectrum can manifest as Dissociative Identity Disorder (DID). Dissociative symptoms are common in adults with a history of child sexual abuse (CSA). Several studies established that 60 -83% of patients with DID have a history of prolonged sexual abuse, characteristically accompanied by physical and emotional abuse as well. [vi]

No one set of symptoms or outcomes can fully characterise a victim's experience. A 1998 study of sixty-two patients meeting diagnostic criteria for Dissociative Identity Disorder (DID) demonstrated that 29% of these highly traumatised individuals had previously been treated for 'schizophrenia', 73% satisfied full diagnostic criteria for Borderline Personality Disorder, 71% met criteria for a current somatisation disorder, 94% had had, or did have, major depression, and 90% satisfied diagnostic criteria for Post-Traumatic Stress Disorder.[vii] (Note: the diagnostic criteria referred to applies to the DSM IV, 1994. The DSM5 was subsequently published in May 2013, and does not substantially alter the criteria for the conditions mentioned).

Other health impacts

People with a lived experience of childhood trauma often present to a health practitioner, commonly a GP. Many will not have connected their current problems and behaviours with their prior trauma, nor will their health practitioner. Failure to recognise underlying trauma can impact both treatment and outcomes.

One study found that 29.3% of women with a sexual assault history reported at least six somatic symptoms compared to 15.8% of other women.[viii] Survivors of child maltreatment are at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms.[ix]

Gastrointestinal (GI) problems may be second only to depression as the most frequent long-term consequence of child sexual assault. One study found that as many as 71% of adolescent girls and adult women, who experience sexual assault for more than two years may later develop GI disorders. Victims of sexual assault are also at risk of higher rates of irritable bowel syndrome; chronic abdominal pain and diabetes; obesity; arthritis; asthma; recurrent surgeries; poor reproductive outcomes; digestive problems and hypertension; and insomnia. [x]

Likewise women with a history of child sexual assault experience higher rates of: venereal disease; pelvic inflammatory disease; respiratory problems and neurological problems ; breast diseases ranging from fibrocystic changes to cancer; yeast infections and one and a half times more likely to have bladder infections.

Research shows that physical and psychological problems are common for victims during pregnancy. The physical and emotional demands of labour and delivery also pose particular challenges for this group of women. Some women report extreme distress during breastfeeding, with bodily contact and the sensations of breastfeeding evoking memories of sexual abuse (Prescott, 2002).[xi] These feelings may result in emotional distancing from the infant, intense feelings of guilt, self-blame and a sense of powerlessness. This may well lead to transmission of generational trauma and poor outcomes for victims and their children.

Interpersonal difficulties

Abusive behaviours and assault, whether physical, sexual or psychological can create long-term interpersonal difficulties. Many victims encounter problems in adult

relationships and sexual functioning due to distorted thinking patterns and emotional distress, and find themselves in re-enactments of past abusive relationships. Such difficulties include fear of abandonment, hypersensitivity to criticism, challenges with trust and intimacy and problems dealing with conflict.[xii]

MHCC propose that child sexual abuse cannot be identified separately from physical and emotional abuse. A study by Palmer, Brown, Rae-Grant and Loughin in 2001[xiii] identified that most victims report a combination of abuse types: physical, emotional and sexual. Indeed the experience of sexual assault is most clearly a physically and emotionally abusive in and of itself. We stress the importance of acknowledging the entire ramifications of child sexual assault in terms of the lived experience of a victim over the life span and over every aspect of their existence.

We therefore ask the Sentencing Council to review the maximum penalty applied to procurement, grooming and unlawful sex with a child as such offences result in the most negative lifelong impacts and poor outcomes for victims.

MHCC also wish to comment on a second matter identified in the following question:

Types of offence
Question 2.3
(1) If the type of offence were to be a criterion for assessing whether an offence should be an SNPP offence, how should it be used?
(2) What types of offence should be SNPP offences?

As the consultation paper describes, there are a number of types of offence that are arguably sufficiently serious to justify a SNPP. The list of SNPP offences already includes groups of offences involving those against the person (sexual assault and violence), drugs and firearms. However, there are a number of other offences in these categories which carry similar maximum penalties but are not included among the SNPP offences.

MHCS propose that in view of the lifelong impacts of child sexual assault on victims that the SNPP can justifiably include these offences so that the penalty is commensurate with the magnitude of an offence that characteristically leads to ongoing risk of disability, disadvantage and frequently results in suicidality, self-harm and early death. We therefore confirm our agreement with 2.11, relating to the review of penalties relating to sexual assault offences, in 2008, in which the Sentencing Council identified “persistent sexual abuse of a child should be an SNPP offence”. However, we refer to our earlier comment suggesting that a hierarchy of trauma experience based on the number of sexual assault events should not be the only consideration. One event or persistent experiences of child sexual assault can be equally damaging for individuals with varying levels of resilience and/or living in different circumstances that can exacerbate the traumatic impacts or support recovery. Therefore setting an arbitrary level of what constitutes “persistent” may lead to miscarriages of justice.

We also agree with the proposal in 2.13, that in order to set offences in context, the Sentencing Council have included all sexual offences against children, not only those that involve a direct “assault” (for example, the serious offences of grooming).

Whilst re-iterating our comment considering the basis in which child sexual assault is considered as "persistent" we concur with the application of a maximum penalty of 25 years' imprisonment as being "appropriately severe". However, we ask the Sentencing Council to be mindful of the research that tells us that that perpetrators brought to the attention of the criminal justice system for 'random' child sexual assault offences have often committed other similar crimes; but shrouded in the secrecy that often accompanies child sexual abuse, their crimes have not been disclosed.[xiv] [xv] [xvi] [xvii] Evidence presented during the Royal Commission Inquiry has shown how often it takes many decades before victims feel able to disclose their abuse histories, and frequently only after another victim has named the perpetrator.

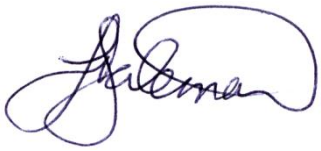
Our view is that the statement that "the appropriate sentence to be imposed is one that is proportionate to the seriousness of the offence, that is in engaging in the persistent abuse of a child" may fail to recognise the long-term impact of single child sexual assault events which may for some individuals be as damaging as persistent abuse, and sets up an arbitrary criteria. In our view it also does not appropriately consider the potential for perpetrators to repeat single events on many victims.

Likewise, we respond similarly to point 2.15, in which the Sentencing Council state that: "in our 2011 background report we noted the need to consider whether various offences of sexual intercourse with a child between 10 and 16 years, should be added to the table because of the frequency of offending, and the fact that they are strictly indictable offences, attracting maximum penalties similar to existing SNPP offences" because this establishes a subjective criteria based on frequency that will be subject to a diversity of community values and belief systems as well as cultural and ethnic context including the personal background and experience of sentencing judges.

MHCC wish to advise the Sentencing Council that we have consulted with our sector in these matters including the national organisation Adults Surviving Child Abuse (ASCA) with whom we work in close partnership in promoting policy reform in the area of trauma-informed care and practice. ASCA are currently involved in providing counselling support and training to the Royal Commission on Child Sexual Abuse and endorse the sentiments expressed in this submission.

We thank you for considering our perspectives in these matters and express our willingness to discuss any matters surrounding this inquiry and the contents of this submission at any time. If such a need arises please contact Corinne Henderson at corinne@mhcc.org.au or telephone: 02 9555 8388 ext 101.

Yours sincerely,



Jenna Bateman
Chief Executive Officer

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