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Making Rights Reality: Final Evaluation report 2014

A pilot project for sexual assault survivors with a cognitive impairment.

Patsie Frawley
School of Allied Health
La Trobe University
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Introduction

People with disabilities are at significantly higher risk of all forms of violence and abuse than the general population (Sobsey and Mansell 1990, Sobsey 1994, Chenoweth 1996, Nosek, Howland et al. 2001, Martin, Ray et al. 2006, Brownbridge 2009, French, Darcel et al. 2010, Hughes, Bellis et al. 2012, Mikton & Shakespeare, 2014). Meta analyses and synthesis of existing studies has shown that people with disabilities have a 50% higher chance of experiencing violence; this risk increases threefold for people with mental health problems (Hughes et al, 2012). Women with disabilities are at a higher risk than men (Cokram 2003, Brownbridge 2006, Martin, Ray et al. 2006, Healey 2013) and people with intellectual disabilities are at a higher risk than people with other disabilities (Horner-Johnson and Drum 2006). However, further work is needed to bridge the knowledge gap about prevalence rates using robust, nationally representative samples (Mikton & Shakespeare, 2014).

In the Australian population it is reported that one in five women have experienced sexual violence including sexual assault and one in 22 men had experienced sexual violence including sexual assault since 15 years of age as reported by people 18 years of age and over (ABS – PSS2013). There is no identification of disability in this data, therefore it is not known if this figure includes experiences of abuse by people with a disability. The Australian Bureau of Statistics reports that one in five Australian reports a disability (ABS, 2013) and research on disability and abuse suggests people with disabilities represent more than a quarter of cases of reported sexual assault (Heenan & Murray, 2007). Despite these findings the full scope and nature of abuse of women with disabilities in Australia is still not known. Recent research that has aimed to ‘build the evidence’ for policy change and the development of primary, secondary and tertiary prevention continues to ask for better data (Healy, 2008; WWDA, 2013) and address the issues in large scale surveys where data on disability of fails to investigate experiences of abuse (for example the ABS Surveys of disability) and large scale surveys about abuse fail to consider disability (for example the ABS Personal Safety Survey).

Research has gained first person accounts from women with disabilities that illustrate the issues faced by them in reporting violence and abuse and in accessing services and supports that adds a qualitative awareness of the issue (Chenoweth 1996, Woodlock, Western et al. 2013; WWDA, 2013.) This body of research on violence and abuse of women with disabilities agrees on a number of important points; that the reported incidence of abuse is lower than the actual incidence, there is a need for better data collection and analysis to strengthen policy, systemic and personal advocacy; more needs to be done to address violence and abuse when it occurs using approaches that have real outcomes for people; and that prevention focused work that is cross sector and uses established and effective
approaches is also needed (Dowse, et al., 2013; Hughes, et al., 2012; Jones et al., 2012 Mikton & Shakespeare, 2014; Mikton, Maguire & Shakespeare, 2014)

Violence prevention and gender based understandings about why violence and abuse occurs has received increased attention globally, in particular through the work of the World Health Organisation and its landmark report on violence and health (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). However, there has been little focus in the disability sector or intersection of the public health ideas and approaches and the disability sector (Mikton & Shakespeare, 2014). This is particularly evident in relation to how violence and abuse of people with a disability is understood in the disability sector and responded to in both the disability and mainstream sectors. Views that attribute the cause of abuse to characteristics of the ‘individual’, particularly for people with an intellectual disability are still prevalent. This view suggests that people with disabilities experience increased abuse because they are inherently vulnerable, due largely to factors relating to their cognitive capacity and supposed passivity and inability to recognise abuse. However these individualised, victim blaming views have been challenged by some researchers (Brownbridge, 2009; Cambridge, 2011; Hollomotz, 2011 Robinson, 2011). These researchers draws on the idea of ‘intersectionality’ Crenshaw (1994) to inform an understanding of what underpins the experiences of abuse of people with a disability. This theory views factors like race, gender and disability as social, political and economic constructs and focuses on how these constructs interact to shape oppression, discrimination and resultant experiences like abuse, for example of women with disabilities. This is a systemic rather than an individual understanding of abuse, and one that informs current research and practice in abuse prevention and response approaches for some of these groups including women with disabilities. (Healey, 2013). This systemic framework for understanding abuse relates well to the social interactional models of disability commonly used in disability policy and research internationally, reinforcing the importance of looking at abuse of people with a disability from these perspectives.

For more than three decades these systemic models have informed disability research, policy and advocacy. The social model is a socio-political model that acknowledges the part social barriers, including attitudes and values about disability, physical and tangible barriers in society and oppressive practices play in creating a disability experience. While this model has been critiqued (Shakespeare, 2006; Shakespeare & Watson, 2001) in particular in relation to its applicability to particular groups, for example people with an intellectual disability (Chappell, Goodley, & Lawthorn, 2001; Shakespeare, 2006), it has been and still is widely used. Importantly, legislation and policy that address disability have embraced and promoted this model using it as the framework for action. One example is the United Nations Convention on the Rights of People with a Disability (UNCRPD) which aims to promote the full human rights of people with a disability through social change and social development (UN, 2014). The UNCRPD and the articles

The UNCRPD and the articles contained in it have become important and unifying advocacy tools for seeking equality and justice for people with disabilities and have provided an important opportunity to raise awareness of issues like violence and abuse of people with disabilities.
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The interactional model of disability was developed in response to research and application of the social model (see Shakespeare, 2006) and expands on the social model to include a view that disability also exists because of the interaction through daily living of ‘impairments’ and a disabling society. Tom Shakespeare neatly describes this as ‘disability as interaction’; “disability is always an interaction between individual and structural factors” (Shakespeare, 2006p. 55)

Central to approaches that align with these models is a focus on equality and inclusion for people with disabilities. In practice two approaches are used to achieve equality and inclusion, ‘accommodations’ which refer to ways of accommodating for a person’s specific needs and ‘adaptations’ which refers to adaptions to the physical and social environments to enable access and inclusion. These approaches aim to change the way society operates to enable people with a disability full and equal access to and inclusion in society, alongside others.

Some commentators argue that the Convention should be interpreted as incorporating “substantive equality” (French, 2007). This refers to both making adaptations that will enable the vast majority to participate (universal design) and providing targeted adaptations and accommodations to meet the needs of groups who despite these ‘universal’ changes still experience difficulties with access and inclusion; in summary, applying a universal approach to access and inclusion and ‘more’, that constitutes ‘more’ is dependent on the situation and the person. It will be determined by how much universal access has already been achieved and what remains to be addressed to give equal access and opportunity for full participation for any given individual. The idea of substantive equality reflects the interactional model for understanding disability that takes into consideration what barriers are left behind once universal accommodations and adaptations are made; in sort what is still difficult for ‘me’ in t his situation wit ‘my’ particular needs and experience of disability. It is the interactional ‘space’ that needs to be considered carefully to determine what adaptations and accommodations, and in some instances what ‘more’ ‘extra’ or ‘different’ approaches are needed to achieve access, equality and inclusion for people with disabilities in mainstream services.

Systemic, interactional and intersectional frameworks for understanding abuse and disability and responding to disability and abuse are central to the program that is the focus of this evaluation; Making Rights Reality: a pilot project for sexual assault survivors with a cognitive impairment. This is a program that has been developed because people with cognitive impairments and/or communication difficulties are recognised as being at higher risk of abuse than the general population and people with other disabilities, and that despite inclusive approaches to counselling and
advocacy within the sexual assault sector (Frawley, 1997, 2000), and despite legal reforms (Successworks, 2011) this group still needs ‘more’ to ensure their equal access to advocacy, support and justice (Camilleri, 2010; Goodfellow & Camilleri, 2003).

Background to the project
The ‘Making Rights Reality’ advocacy pilot project (MRR) was Part Four of a broader range of research, policy advocacy and legislative reform developed to address the inequities faced by people with a cognitive impairment and communication difficulties who experience sexual assault (Goodfellow & Camilleri, 2003). This work has spanned a decade. It acknowledges that “achieving justice for victims of sexual assault with a cognitive impairment or communication difficulties is an enormous challenge for the criminal justice system” (Federation of Community Legal Centres 2011 p 5). In Victoria over this timeframe legislative reforms have been implemented to address some of these inequities in the justice system (“Crimes (Sexual Offences) Act,” 2006). Central to these reforms were the 202 recommendations contained in the Sexual Offences: Law and Procedure – Final Report (Victorian Law Reform Commission, 2004), of which 18 related directly to complainants with cognitive impairment. An evaluation of the implementation of these recommendations found that overall they have begun to impact on outcomes for victims of sexual assault, with particular positive shifts being reported in supporting people with a cognitive impairment (Successworks, 2011). However, as the MRR project proposal states “There are still significant non-legislative reforms [needed] around the particular needs of people with a cognitive impairment” (FCLC, 2011 p. 5).

Improved advocacy for victims with a cognitive impairment and/or communication difficulties is one of these ‘non-legislative’ reforms identified through Sexual Offences Reform consultations. It is referred to as having a ‘central role’ for better outcomes for victims with a cognitive impairment or communication difficulty and as being ‘vital at all stages of the justice process’ (Goodfellow & Camilleri, 2003) and further reinforced by Camilleri (2008; 2010) as a significant factor in the progression of sexual assault reports through the justice system. The role of advocacy in the context of the MRR project is to “explicitly advocate the wishes and best interests of the complainant, ensuring they are heard and their choices respected wherever possible” (FCLC, 2011).

The pilot project was designed to directly address this advocacy need through enhancing existing sexual assault services provided by Centres Against Sexual Assault (CASAs) and strengthening legal advocacy through a dedicated legal

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1 The definition of Cognitive Impairment used in the MRR project includes people with Acquired Brain Injury, people with an intellectual disability and people with dual disabilities - which might include a person with an intellectual disability and mental illness or ABI and an intellectual disability.
program. In addition, it aimed to address some of the systemic factors that impact on outcomes for this group through training and resourcing other organisations that interact with people with a cognitive impairment who report sexual assault, including the Police and disability services. The model also reflects recommendations made in the Parliament of Victoria Inquiry into access and interaction with the Justice System by people with an intellectual disability and their family and carers (Parliament of Victoria, 2013), in particular recommendations relating to the work of the Police, the Office of the Public Advocate (OPA) Independent Third Person Program (ITP) and the need to develop better data on the experiences of victims of crime with an intellectual disability.

**Evaluation Method**

The evaluation of the pilot project looked closely at the project activities and aimed to find out how they were implemented, what impact the project was having as it was being implemented, and what factors, both within the project and externally, were impacting on the implementation.

The focus questions for the evaluation were:

To what extent has the pilot project met its aims to increase access to specialised advocacy support for people with cognitive impairment and/or communication difficulties?

What factors have impacted on the project implementation?

What have been the experiences and outcomes for victim/survivors as a result of the project?

Has the project increased access to the legal process, in particular crimes compensation?

How have related services engaged with the project and what outcomes have they experienced?

The approach is summarised below;

A Program Theory Evaluation approach will be used to guide this evaluation. This approach recognises the already well developed program theory of the project and seeks to find out how the stated aims of the project are implemented, what factors support or challenge this implementation and if the aims are met. This approach seeks to find out if the “Project theory” or logic work whether a pilot program should be extended and what would be needed to implement it more broadly (Rogers, Petrosino, Huebner, & Hacsi, 2000). This fits well with the MRR as a project model has been clearly articulated (FCLC, 2011) and short term, intermediate and long term outcomes have been defined. (Frawley, 2011, p. 2).
The evaluation had ethics approval from LaTrobe University Human Ethics Committee (23, August 2012) and Southern Health Ethics Committee (19 September 2012). While the evaluation activities outlined below did not begin until ethics approval was provided, the evaluator did attend MRR reference group meetings prior to these dates as agreed to by the reference group.

### Data collection

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<tr>
<td>MRR reference group meetings x 3</td>
<td>MRR reference group meetings x 3</td>
</tr>
<tr>
<td>MRR reference group focus x 1</td>
<td>SECASA Counsellor/Advocate individual interviews x 6</td>
</tr>
<tr>
<td>SECASA &amp; SMLS project workers; group interview x 1; individual interviews x 1; case study development and analysis x 6</td>
<td>SMLS/SECASA sexual assault clinic coordinator x 1</td>
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<td>Pre program SECASA data analysis; 12 month service use data analysis (SECASA &amp; SMLS)</td>
<td>External organisations individual interviews: 1 ITP program; 1 Courts (N=3); 1 x Women with Disabilities Victoria (N=2)</td>
</tr>
<tr>
<td>SECASA Counsellor/Advocates focus group (N=25); Survey N=24</td>
<td>SECASA project worker interview x 1; SMLS project worker interview x 1</td>
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In addition, desk-based research was undertaken to determine how the project was understood and promoted in the disability, legal and sexual assault sectors. Contact was also made with Victoria Police SOCT members although interviews were not conducted.

### The MRR model

Mainstream services like CASAs and community legal centres see a very broad range of clients - people from all parts of the community, with a broad range of experiences and with a range of socio-cultural lived experience. Issues like mental illness, disability, limited economic means, social isolation and cultural diversity are all represented in client groups. In many ways therefore, these services are constantly ‘adapting’ and making ‘accommodations’ so that this broad client group can have access to their services in a way that meets their
needs. However, as one SECAS A staff person interviewed for this evaluation noted,

The research tells us we should be seeing more people with a cognitive impairment than we are seeing... what more do we need to do to enable them access to our [sexual assault] services?

The MRR program asserts that what is needed is an enhanced service, not a different one. Components of this enhanced service are; a dedicated advocacy support process within sexual assault and legal services, adapted approaches to counselling, adapted approaches to legal advocacy, use of accessible information for clients in counselling and in their engagement with legal services, and systemic advocacy that raises awareness in the disability and sexual assault sectors about responding to sexual assault. Further it asserts that CASA staff need to be available to victims of sexual assault with a cognitive impairment and/or communication difficulty early in their reporting to ensure effective individual advocacy throughout the counselling and legal process (for example in the police interview and at the Crisis Care Unit), and where possible provide consistent support.

The overall aim was therefore;

To increase justice for people who have been sexually assaulted and have a cognitive impairment and/or communication difficulties by establishing pathways and opportunities for victim/survivors to access professional, appropriate and specialised services to advocate for their current and ongoing needs independent of families, friends and carers (RCLC, 2011).

Specific approaches to meet this aim in the MRR program were:

Building on the existing infrastructure and skills of agencies who are already working with victim/survivors of sexual assault or people with a cognitive impairment and/or communication difficulties;
Providing advocacy and support during dealings with police and prosecutors, including police interviews. Victims will be able to access crisis support through a 24 hour service;
Providing ongoing advocacy and support during investigation, prosecution and court processes. Victims will be helped to monitor, understand and participate in these processes;
Providing legal and other advice on criminal justice processes which will occur and the possible outcomes as well as advice on the options and services available to them;
Providing legal support to access crimes compensation and explore other compensation options;
Providing a skilled communication support service and other disability support services where required.

These core components of the project are depicted in the following figure:
Identification of clients for MRR

Identification of the disability status of people accessing mainstream services is problematic. Many services rely on self-identification, for example by ‘check marking’ a box on an intake form. It is well documented that these approaches are not working in the identification of people with disabilities in services like domestic violence, sexual assault, other health services and interaction with the justice system (WWDA, 2013; Woodlock et al. 2014). The MRR program developed a multi-faceted approach to identify people with a cognitive impairment and/or communication difficulties. Firstly training of Counsellor/Advocates in disability awareness was undertaken by the Office of the Public Advocate, SCOPE and the MRR project worker. This was supplemented by establishment of a resource made available to all staff that included information about a range of disabilities covered by the broad term cognitive impairment and communication difficulties. This knowledge was then used during the intake process by the SECASA duty workers who looked holistically at referrals to determine whether the client might have a cognitive impairment and/or communication difficulties. This process included the duty worker asking the client or the referrer about any disabilities which were identified for example at the crisis presentation through the Counsellor/Advocates assessment of the person using their knowledge of disability and through accessing
When a client is identified as meeting the criteria of the MRR program, the MRR project worker is informed and the process of counselling, advocacy, and referral to legal advocacy continues. Figure 2 depicts this process.

**Evaluation Findings**

MRR sought to address three issues faced by people with cognitive impairments and/or communication difficulties who experience sexual assault. It aimed to: increase access to specialised advocacy and counselling; increase access to the justice system including crimes compensation; and to influence the way ‘related services’ understood and responded to the needs of these victims of sexual assault. The model depicted in Figure 1 outlines how the program was designed and implemented to achieve these aims. This section of the report presents analysis of quantitative and qualitative program data that reflects what was achieved, and discusses how these achievements were made, the barriers and limitations of the program, and factors that still remain to be developed or addressed for full and effective impact.

Disability organisations and the Police accounted for almost 40% of referrals to the MRR program. Self-referrals by people with disabilities were the highest individual category accounting for 22% of referrals.
implementation of this program. The findings address the three aims outlined above.

Limitations – MRR data
There are some limitations with the MRR data, including the fact that it is a focussed sample in one service and only captures information about people who have reported their abuse. It is well known that reporting is in itself a difficult task for people with a disability, particularly those who have more severe levels of disability and disabling experiences such as little or no communication and high dependency on others in all aspects of their lives. It is therefore not surprising that the majority of clients who used the MRR program were identified as having a mild level of disability.

Identification of disability is also dependent on the judgement of the CASA worker, and while their skills were honed through the program, the identification process is somewhat arbitrary. In addition, there is some missing data. However, it does indicate that with a small focussed sample there is some confirmation of key themes and patterns of abuse raised in the research, in particular in relation to gender, profile of perpetrators and places of risk. These findings can and should inform advocacy, policy and practice reform.

Referrals
Disability organisations and the police account for almost 40% of referrals to the MRR program, with disability organisations making referrals in 20% of cases and the police, in particular Sexual Offences and Child Abuse Investigation Teams (SOCIT) in 19% of cases. Self-referrals are however the highest individual category, with 22% of cases indicating the person made a self-referral. The next highest referral category was families who referred in 15% of the cases. It is not known how many of the referrals made by disability organisations or the police were also the result of a person disclosing or reporting abuse to them; it is likely that there were a number in this category. There were a broad range of people and services making referrals, including general community services, health and mental health services, schools, Centrelink and in one case a church leader but there are four key groups; self-referrals, disability services, police and families. It is not clear if there is a link between the community education and awareness raising efforts of the MRR program and these referral patterns, but it is interesting to note that there was a concerted effort to inform disability organisations and the police in the south eastern region about the MRR program, and these two groups combined made up almost half of the referrals.

Mainstream and disability services clearly need to be aware of and responsive to sexual abuse of people with cognitive impairments to ensure that the abuse is identified and that victim receive the services they need and want. Nevertheless, the MRR referral data confirms an important point made in the disability and abuse research (Chivers & Mathieson, 2000) that regardless of the capacity of

While disability organisations need to be able to identify abuse and then report it the MRR referral data strongly suggests that an equal if not bigger effort should be made to ensure people with disabilities can independently disclose and report to mainstream services like the CASA and Police.
organisations to identify and report abuse it is still people with disabilities themselves who are the main reporters of their own abuse. This information is important for a number of reasons, not least that currently there is a focussed effort by some disability organisations on ‘safeguarding’ for abuse and many of their approaches rely on staff identification of abuse and internal reporting policies and guidelines. The MRR data on referrals strongly suggests that an equal if not bigger effort should also be made to ensure people with cognitive disabilities know how to disclose and report abuse, in particular directly to organisations like CASAs and the police.

In the two year period of the MRR project, February 2012 to February 2014 there were 108 intakes, representing 102 people with a cognitive impairment (there were 6 repeat clients) who accessed the MRR program in this same time period. This represents just over 4% of all SECASA intakes. In the first year of the program there were 59 MRR intakes and in the second year 49 intakes. An analysis of the first year program data is reported in the First Evaluation Report (Frawley, 2013). This indicated that there was a threefold increase of people identified from the pre-program data to the Feb 2012 to Feb 2013 data. While the second year data indicates a more steady number of clients (49 in year two compared to 59 in year one), overall it is clear that the MRR program has increased access to SECASA counselling and advocacy for this client group.

Reasons for this increase in service use could include SECASA staff having more knowledge and awareness of disability because of training and an increase in their skills in identification of cognitive impairment and/or communication difficulties, external services being more aware that referrals could be made to SECASA for this client group, and/or a shift in public awareness about sexual assault of people with disabilities leading to more reports of abuse and more referrals. During the project timeframe there were a number of reports in the media about sexual and physical abuse of people with disabilities in government funded residential services in Victoria (see for example ‘Abuse of aged and disabled on the rise’ The Age 14 October, 2012/10/12; and ‘A monster in the house’ The Age 21 November 2013). While there is no way of knowing what impact these reports may have had on people’s awareness of abuse and subsequent reporting it could have been a factor.

The evaluation did not include interviews with people making referrals or ask clients what led them to self-refer, and therefore it is difficult to know which of these factors were at play for any particular referral. It is likely that they have all played a part in the increased number of people with a cognitive impairment being identified by SECASA and the subsequent increased access to and use of the service by people with a cognitive impairment. One key factor that was identifiable was the increased awareness of the program through community education and promotion of the program by the SECASA project worker with Victoria Police, the courts and the disability sector. This included some partnership work for example in the development of the Easy English information sheets (SECASA, 2013). Impact
on and engagement with ‘related’ services and sectors through the program will be discussed later in the report.

The following section analyses the MRR client data to provide a profile of the clients who accessed the service, an overview of factors related to their referrals and the sexual assaults, and an overview of the counselling and advocacy services provided by the MRR program. The primary data source was the MRR case summary table developed by the SECASA MRR project worker using intake and case file information.

**Increasing access to specialised advocacy and counselling**

In the MRR pilot period, February 2012 to February 2014 SECASA had 2960 adult intakes (the total number of intakes including children was 4549); 2575 women and 385 men (SECASA, 2014). Over 30% of these intakes were for people between the ages of 15 and 25 years of age; again these were mainly young women (N=475). A further 25% were aged between 40 and 50 years of age. There were 48 children between the ages of 0 to 4 years of age and 3 intakes for people aged over 80 years of age. This data includes the 108 intakes for people who were identified as having a cognitive impairment.

**MRR Client profile**

One hundred and two people (108 intakes) were identified by SECASA as fitting the criteria for the MRR program from February 2012 to March 2014; they were identified as having a cognitive impairment and/or communication difficulties by SECASA workers. The profile of this group is outlined below (Figure 2) and discussed in the following sections.
Figure 3 MRR Clients N 102

Gender, age, disability

People presenting to SECASA and identified by the MRR program from 2012 to 2014 were; mainly women (over 80%), and more likely to be identified as having an intellectual disability (58%). They were mainly clustered in two age groups: 20 – 29 years of age (over 36%) and 30-39 years of age (over 37%); however, more women were aged in the 20-29 years age group than men (F33, M4), and the most common age group for men was between 30-49 years of age (over 52% of the men were in this age group). The MRR program saw almost four times more women than men, which correlates with the general population data on sexual assault in Australia that reports women are four to five times more likely to report sexual assault than men (ABS, 2013) and with the SECASA data for the same period where intakes for women were six times more than intakes for men. However, almost 20% of people seen in the MRR program were men, indicating the importance of recognising and responding to issues of sexual assault for men with cognitive impairments.

Differences between the MRR client profile and the profile of the general population who report sexual assault was most marked in relation to age; the

In 75% of cases the alleged offender was known to the victim including the following relationships: family member including father, step-father, brother, cousin (25%) including one incident where a mother abused her son; acquaintances including friends, neighbours and a priest (19%); boyfriend or ex-partner (13%), fellow resident, employee or student (8%) and carers and disability support workers (8%).
mean age of clients of the MRR program (women and men combined) was 31.5 years of age. This is higher than the Australian general population sexual assault data which identifies the highest represented age group as the 10 to 14 years age range for both females and males (ABS, 2013). The MRR program is promoted as focussing on adults, which would account for the profile of MRR clients being older than the general population data. The MRR program did also see young clients: the youngest female client was 12 years of age and the youngest male was 17 years of age. Regardless, when compared with the general population the MRR program has seen an older cohort of clients, with the most common age group seen in the MRR program being 20 – 39 years, while in contrast this was the third smallest group in the general population (ABS, 2013).

Disability type was ‘assigned’ by the SECASA Counsellor/Advocate either at intake or in their counselling notes. In some cases the client may have self-identified as having a particular disability type - the data does not indicate how the disability type was determined. Based on this data, people with an intellectual disability were the highest users of the program at 58% (N = 59) of clients. A person was ‘counted’ as having an intellectual disability as their primary disability where ID (intellectual disability) or CI (cognitive impairment) were noted in the data table (MRR case summary table). In some instances one or more other disability types were also indicated. These included Psychiatric Autism, Aspergers, Downs Syndrome, Cerebral Palsy, Bipolar, and, in one instance, Acquired Brain Injury (ABI). This could indicate that the person had a dual disability (if the details of their disability were gathered directly from the client or at referral from other sources), or that the Counsellor/Advocate was not sure and using their knowledge, skills and information made available to them determined that the person had one, other or both disability types. While SECASA Counsellor/Advocates received training on disability, had access to reference materials about disability and for some would have professional knowledge of disability the identification of ‘disability type’ was to some extent arbitrarily determined.

People identified as having an ABI were the second most frequently identified group at 19.6% (N=20). Combined, intellectual disability and ABI account for almost 78% of the clients of the MRR program. Sixteen people had communication difficulties, including one who used a communication aid and one who had no speech but who did not attend for counselling. For some people whose disability is identified as ID or ABI, speech difficulties were also noted.

Mental health alone was identified as the primary disability of almost 6% of the clients. Again, this might have been due to the Counsellor/Advocate having difficulty determining a primary disability on the information available to them, or difficulty distinguishing between cognitive disability and mental health, or it may have been that if these people self-identified this was their primary disability. Also psychiatric disability is considered a cognitive disability within the ITP guidelines, in

58% of the MRR clients were identified as having an intellectual disability
People identified as having an ABI accounted for almost 20% of the MRR program
More than half of the clients were identified as having a ‘mild’ level of disability with almost one quarter identified as having moderate and one quarter severe levels of disability.
The majority of clients had experiences a recent sexual assault.
some of these cases they were referred by police using the ITP definition. Taken as a whole picture of the ‘type of cognitive impairment’ of people using the MRR service, this data does indicate that intellectual disability is the most common and that in many cases a person may also have dual or more than one ‘disability’ or ‘impairment’ types.

Level of disability was also noted in the data table. More than half of the clients were identified as having a ‘mild’ level of disability (58%) with almost one quarter being identified as having a moderate level of disability (24.5%) and the remainder identified as having a severe or significant level of disability (17.5%).

Sexual assault: time, place, perpetrator

Of the 108 intakes, 13 related to sexual assault that had occurred before 2012, with one case noted as happening over 20 years ago and another noting multiple incidences of sexual assault occurring over many years and in many locations, including institutions and prison. The remainder of cases were recent assaults.

Perpetrator/ Alleged Offender

In 75% of cases the alleged offender was known to the victim including the following relationships: family member including father, step-father, brother, cousin (25%), including one incident where a mother abused her son; acquaintances including friends, neighbours and a priest (19%); boyfriend or ex-partner (13%), fellow resident, employee or student (8%) and carers and disability support workers (8%). Strangers including people met online accounted for 15% of alleged offenders and transport providers including disability agency bus drivers and taxi drivers for 6% (the latter may not be strangers if the person is a regular user of that transport). In 4% of the cases the alleged offender is not reported in the case summary table.

There is a strong correlation between this data and the general population sexual assault data in Australia, where it is reported that in 80% of cases the alleged offender is known by the victim (31% family members and 49% other relationships) with strangers accounting for 15% (ABS, 2013). One distinguishing factor in the MRR data is that in at least 16% of cases the alleged offender is in contact with the client in a place or relationship that is associated with the person having a disability (carer, disability support worker, fellow resident/student). Also, if the category of transport provider is added to ‘known by’ rather than ‘stranger’ it increases to 21% of cases.

Location

Place of residence or a ‘home’ is the location of 56% of cases of sexual assault of clients in the MRR program. In 40% of cases the abuse occurred in the victim’s home including family home (34 cases) or residential facility (7 cases), and 16% in...
the alleged offenders’ homes. This reflects closely the general population sexual assault data in Australia where it is reported 60% of cases occurred in a ‘private dwelling’ and 5% at another residential location (ABS, 2013). In 20% of MRR cases the place of abuse is not noted in the data table. Other locations noted included ‘on or in transport’ where the alleged offender was a transport provider, at workplaces where the alleged offender was a co-employee, school or other educational facility where the alleged offender was a teacher or co-student, and public place where the person was a stranger. Public places included train stations and a pub.

MRR client and abuse profile
The program data strongly suggests that people with a cognitive impairment are at most risk at home or in their place of residence, from people they know and trust, and/or rely on for support. This includes family members, paid staff and, if we are to include transport providers as being ‘known’, people like bus and taxi drivers. Of the ‘strangers’ there were three cases where the person was a stranger ‘met’ through some form of ‘online’ communication and others were people in public places. In summary, the perpetrators were in the main known to the victim and the abuse occurred in homes or ‘home-like’ sites.

Places of risk for the MRR program clients and perpetrator profiles reflect those of the general population and what is known from disability research about abuse of people with a disability. Importantly the MRR data highlights that people with a cognitive impairment do need safer living environments and safer relationships. It also shines the light on the ‘private’ nature of abuse of people with cognitive impairments, in particular the private domain of families and the ‘caring’ relationship, or what Cambridge (1999) describes as the ‘corruption of care’. This occurs in both paid and unpaid ‘caring’ relationships that people with a cognitive disability are a part of because of their disability, relationships where they are dependent on others who can and do control them. Some researchers have called this ‘disability related’ abuse.

Counselling and advocacy
Increased access to enhanced sexual assault counselling and advocacy for people with a cognitive impairment depends upon three factors: the existence of a service people can access; referrals to it; and the expertise within the service to provide an enhanced service. This section will discuss these aspects of the MRR program with reference to the case summary table and qualitative data gathered in interviews with the MRR project worker and SECASA counsellor/advocates who provided a service to people with a cognitive impairment during the pilot phase of the program.
Focus and number of sessions

Counselling and advocacy are the key services provided by SECA to all clients. Counselling refers to the therapeutic work done with the client normally in individual sessions, and advocacy is a broad range of work the counsellor/advocate does both with the client and with external people and services ‘on behalf of’ but with the knowledge and consent of the client. The work undertaken with MRR clients as noted by workers falls into the following categories: crisis response; counselling only; information to parents or others; advocacy with police; liaison with disability services; and VARE (Video Audio Recording of Evidence, in conjunction with ITP role) and court support. In over 40% of cases a combination of counselling and advocacy or liaison with either disability services, parents or both was noted, and in a further 36% counselling only was provided. The remainder involved ITP support and/or support with the VARE or crisis care only.

People referred to the MRR accessed from 1 to 23 counselling sessions, with most attending between one and five sessions (32 clients), followed by six to 10 sessions (14 clients). Twenty-nine people either failed to attend the scheduled counselling session or chose not to attend counselling after receiving support either at the Crisis Care Unit (18 people – 5 out of region) or at the police interview where the SECA worker was the Independent Third Person (3 people – out of region). This data indicates that MRR clients are attending on average 3.2 sessions however 11 people attended more than 10 sessions. It is also clear that some clients are not choosing to attend beyond the Crisis Care Unit appointment; with 17% of MRR clients making this decision.

The MRR program provided clients with access to the full range of support that other clients of SECA could expect to receive. What differed, according to Counsellor/Advocates interviewed for this evaluation, was the involvement of and with ‘others’ most often families and disability service providers in the counselling and/or advocacy. One Counsellor/Advocate noted that at times it was difficult to ensure the focus was on the client and to ensure the approach was being driven by the client. In some cases Counsellor/Advocates noted that it was others including families or external advocates/service providers who were the focus. This was a challenge to the Counsellor/Advocates and to the principles of CASA work, driven as it is by a client-led approach. Most Counsellor/Advocates interviewed noted that this was more often the case with clients with moderate to significant levels of disability and additional needs such as limited verbal communication. Combined this group made up less than half of the overall MRR client group.

Enhanced counselling and advocacy

Before the MRR program I did not think I had anything to offer a client with a cognitive disability…now I know I can at least offer the counselling and advocacy I offer any other client (SECA Counsellor/Advocate)
SECASA Counsellor/ Advocates are a highly trained and experienced group of professionals with a broad range of tertiary qualifications and practice modalities. Focus group and individual interviews with these practitioners found that this experience underpinned their approach to providing counselling/ advocacy to clients with cognitive impairments in the MRR program. Working with clients with a cognitive impairment and/or communication difficulties is something all SECASA Counsellor/ Advocates are expected to do and are resourced to do through the MRR program. Most reported that they were confident in their work with this group and felt well supported by the MRR project worker. Access to the MRR project worker, who they saw as having focussed expertise for working with the MRR client group, was reported as the most useful component of the program. Counsellor/ Advocates mainly accessed this worker for secondary consultation and ‘problem solving’ in relation to advocacy in particular.

The Counsellor/ Advocates found the Easy Read materials developed by the project worker in consultation with SCOPE, SMLS and the courts and now available on the SECASA website very useful in their work with the MRR clients and used these more than other resources. Most relied on their usual approaches to counselling, adapting their approach to the specific needs of the client by using pictures, the Easy Read information minimising ‘talking’ and supplementing talking with stories/ books, pictures and other therapeutic tools. More research is needed to better understand the counselling approaches used with clients with cognitive impairments and the effectiveness of these approaches. Most of the Counsellor/ Advocates suggested that adapting counselling practices to meet the needs of clients with disabilities is something all experienced Counsellor/ Advocates should be able to do and that access to resources and secondary consultation as provided in the MRR program was usually all that was needed to make the counselling and advocacy accessible and effective.

The MRR program also had provisions for brokering additional supports and services through a brokerage fund; this fund was only accessed in one case to provide care during a court appearance. Counsellor/ advocates knew about the fund, but they reported that in most cases where support was needed to attend counselling sessions or within a counselling session it was provided by the disability support service, family members or other advocates. Additionally, when looking at the profile of the MRR clients, most were people with a mild disability which suggests they may not have had needs requiring additional support. If more clients had more complex disabilities, this would increase the need for access to additional supports.

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The survey of SECASA Counsellor/ Advocates found that SECASA staff were highly experienced sexual assault practitioners. Almost 30 per cent (29.2%) have more than 10 years experience in this field with 25 per cent having between 6 and 10 years experience. In addition 100% of those surveyed have a tertiary qualification; 75 per cent with either a first, second or post-graduate qualification.

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in counselling or in accessing legal support. The brokerage fund should therefore be considered as a key component of the ongoing program, in particular if the client profile were to change.

The effectiveness of the enhanced counselling and advocacy provided by MR R is difficult to assess without gaining insights from the MR R clients themselves or families and others who supported the clients. This is a limitation of the evaluation but the scope and nature of this evaluation did not allow for this level of research. Future research and evaluation of targeted, specialist programs like MR R would benefit from gaining these insights. It is clear from the MR R data and from interviews with Counsellor/Advocates that clients of SECASA with a cognitive impairment received at least the same opportunities in counselling and through advocacy as other SECASA clients.

The following case study provides some insights into the way the MR R program worked for one client ‘Dana’. In particular this case study highlights the intensity of the counselling which Dana attended weekly and over an 18 month period. It also outlines the range of approaches used by the Counsellor/Advocate in their therapeutic work and the ‘reac’ of the counselling/advocacy which Dana’s family also received.

Case Study - DANA

Dana is a young woman in her mid-teens with autism and an intellectual disability. Dana was sexually assaulted in her home by a man working in her local area. The sexual assault was reported to police soon after it occurred. Dana was brought to the SECASA Crisis Care Unit, where she was provided with information and support by a Counsellor/Advocate, in addition to having a forensic medical examination.

Following this Dana attended SECASA for ongoing counselling over a period of approximately eighteen months, initially weekly, and then gradually reducing over a number of months. Counselling addressed the impacts of sexual assault, and provided information and support in relation to legal processes. Dana’s Counsellor/Advocate used resources such as picture cards, photos and protective behaviours resources to assist in the therapeutic work.

Dana’s family was also provided with counselling and support to navigate the justice system. The case went to trial. Brokerage was used to provide disability support to Dana on the days she was not required to attend, whilst her family attended court.

The alleged offender was found not guilty, despite being an adult male and Dana being under sixteen at the time of the offence. Dana made an application to the Victims of Crime Assistance Tribunal (VOCAT) through a private legal firm, with the outcome not yet known.

Dana decided that she no longer wanted to attend counselling, although is aware she can recontact if needed in the future, as are her family. She is attending a women’s group.
Increased access to the legal process
Springvale Monash Legal Service (SMLS) was the community legal centre involved in the MRR program. SECASA and SMLS have had a long association, in particular through the sexual assault clinic run at SMLS. This joint clinic between SECASA and SMLS was established to address the legal advocacy needs of victims of sexual assault and has operated for over twenty years. The clinic at SMLS is staffed by volunteers and law students from Monash University who are completing a unit in professional practice. This clinic receives referrals from SECASA for clients who wish to pursue Victims of Crime Compensation.

Despite its longevity, it was recognised by both organisations that people with a cognitive impairment or communication difficulties were not highly represented at this clinic, even though the clients were also seen at SECASA. Anecdotal information suggests there may have been as few as three clients who were identified as having a cognitive impairment. There is no clear explanation for this, but the low numbers of clients identified as having a cognitive impairment by SECASA in the six months prior to the MRR (1.96% of their overall clients) helps to understand this low figure. In addition, it could have been that without a dedicated worker at SECASA or SMLS these people may not have been identified by the service or by those making the referral, or they were simply not referred.

While the MRR program strengthened the focus on clients with a cognitive impairment in the SMLS and SECASA joint clinic, the focus of the legal advocacy for these joint clients was on victims of crime compensation. Clients of the MRR program also had other interactions with the justice system in relation to the sexual offences. These included support through the ITP component of the program and liaison between SECASA and the SOClT police and courts that did not involve the SMLS project worker. Some MRR clients also had historical cases that had been or were being dealt with by the justice system. The following section will report on the outcomes for clients from their contact with SMLS, and other legal outcomes where they were known by either SMLS and/or SECASA.

Legal outcomes
Research reports that there are number of systemic issues within the legal system that impact on access and outcomes for people with a cognitive impairment and specifically for victims of sexual assault with a cognitive impairment (see for example Goodfellow & Camilleri, 2003; Camilleri, 2010). While legal reforms have aimed to address some of these barriers, and recent studies indicate there have been some improvements (Successworks, 2011), barriers to justice still remain for victims of sexual assault in the general population and in particular victims of sexual assault with a cognitive impairment.

The following section outlines how the MRR program was implemented to increase access to the justice system for clients and describes the outcomes, albeit within a system that is struggling to accommodate the needs of this group and within a
short time frame of two years. A number of case studies from the program are included to highlight the experiences of the MRR clients and the way the program worked to achieve these aims.
Nadia is in her mid-twenties, has an intellectual disability and attends a day program. Nadia disclosed that the driver transporting her to the day program had been sexually assaulting her. There had also been disclosures from other women using the same transport. A report was made to the police (SOCIT) and Nadia was referred by disability support staff to SECASA for counselling.

Nadia attended counselling over an eighteen month period on a monthly and bi monthly basis. In between counselling sessions she received telephone support from her Counsellor/Advocate who also provided information and support to Nadia’s family.

Counselling involved trauma and play therapies and the use of easy-read materials and resources. General information about sexual assault and protective behaviours was also provided. The court case progressed to a mentions hearing, the offender pleaded guilty and was sentenced to two years community service. Nadia was not required to attend court.

Nadia was referred to the specialist legal clinic run by SECASA at Springvale Monash Community Legal Service where an application was made to the Victims of Crime Assistance Tribunal (VOCAT). One requirement of the VOCAT application was that Nadia see an independent psychologist for an assessment. Nadia’s mother wished to make an application to VOCAT as a secondary victim so that she herself could access counselling; however as Nadia was an adult this was not possible. This was a difficult decision for Nadia’s mother as she had always perceived Nadia as a child and therefore automatically thought the legal system would also acknowledge this status.

A barrister briefed by SMLS appeared at the VOCAT hearing on behalf of Nadia and Nadia and her family attended the hearing. VOCAT made an award to assist in Nadia’s recovery which included a monetary payment ($10,000), a holiday, self-defence classes, counselling and legal expenses.

After eighteen months of counselling at SECASA the decision was made between Nadia, her family and her Counsellor/Advocate that she no longer needed to attend as she was doing well.
applications. While there are other avenues of compensation available to victims, VOCAT (Victims of Crime Assistance Tribunal) claims are the most common through the SMLS clinic. This focus is also reflected in the work with the MRR clients; while other advice was given for example regarding intervention orders and advice on the criminal court process, VOCAT applications accounted for the majority of the work done by the SMLS MRR worker.

As indicated in Figure 2 earlier, the approach taken with all MRR clients at SECASA was to provide information about their legal options, including information about VOCAT and the dedicated service available through SMLS as part of the MRR program. In 28 of the 108 MRR intakes at SECASA the client was either referred to or given information about the SMLS MRR service. For the remaining 11 where data was kept on legal services/support, people either chose not to pursue this option, were out of the region, were historical cases where compensation had been provided, the crime occurred interstate or in two cases, there was a conflict of interest where the alleged offender was a client of SMLS.

In 10 cases applications were made for VOCAT and at the time of writing three clients had been awarded compensation. In the three successful applications the victims were awarded amounts under Special Financial Assistance – a monetary payment that can be used as the victim sees fit, including for amounts to cover holidays, counselling costs, cost of classes including self-defence training, costs to cover items including a personal alarm and legal costs to cover the work of SMLS (a set fee of $870) and the Barrister’s appearance at VOCAT. These items are determined by the client in consultation with the SMLS lawyer who takes into consideration reports from SECASA and the independent psychologist, together with other information about the impact of the crime that is made available during consultations.

It was estimated by the SMLS project worker that the average time spent on MRR client files was 35 hours. The following case study outlines the extent of the work undertaken by the SMLS MRR project officer and coordination with SECASA for legal advocacy. It also highlights the complexity of this work and the importance of the one dedicated lawyer providing ongoing advice and support throughout the process.
Case Study - Catriona

Reporting to police

It is widely known that all sexual violence is under-reported, with only 19% of sexual assault victims reporting to police (ABS 2013). Research by the Victorian Disability Discrimination Legal Service about the experiences of victims of sexual assault with a cognitive impairment found there were a number of barriers to these victims reporting, including fear of notification of other authorities, lack of capacity to self-report and the lack of awareness of the disability sector about sexual assault (Goodfellow & Camilleri, 2003). While other factors in common with the general population may impact on the levels of reporting of sexual assault by victims with a cognitive impairment, there is a dearth of research about this that seeks a perspective from people with cognitive impairments.

Of the 108 MRR intakes from February 2012 to March 2014, 78 (72%) had been reported to the police, including 10 historical cases. A snapshot of three months of data for adult intakes at SECASA indicates reports to police fluctuate: 57% (December 2013), 46% (January 2014) and 65% (February 2014). The overall SECASA reporting rates are lower than for the MRR client group overall, but higher than those reported for the general population (see ABS 2013), suggesting that contact with a CASA may have a positive impact on reporting to police. Additionally, the current Victoria Police practice requires that they take victims of sexual assault to a CASA Crisis Care Unit when the assault recent. This may also...
have impacted on this data. While it is beyond the scope of the evaluation to conclusively ascertain why the figures are higher for MRR clients, it may be due to various factors, including the close working relationship between SECASA and the police generally, and the increased awareness of support for clients with a cognitive impairment through the promotional work of the MRR project worker with police. The co-location of CASAs with SOCIT units at the Multi-Disciplinary Centres (MDCs) may also be having an impact on rates of reporting of sexual assault to police.

Advocacy – police interview

A further component of the MRR program which aimed to enhance advocacy is the provision of a SECASA Counsellor/Advocate as an Independent Third Person (ITP) at the police interview. The ITP program is managed by the Victorian Office of the Public Advocate (OPA). This program was developed to address issues being faced by people with a cognitive impairment in their interactions with the justice system; in particular their over-representation as victims and as alleged offenders.

Research in the late 1980s that focussed on people with an intellectual disability found that this group may be at particular disadvantage in the police interview where they may not fully understand questions put to them, their rights in the interview or the consequences of the interview (OPA, 1987; Johnson et al., 1988). These studies made a number of recommendations to protect the rights of people with an intellectual disability in their interactions with the justice system, including the recommendation that they have access to an independent advocate during the police interview. This led to an amendment of the Police Standing Orders in 1988 to make such an independent advocate available to people with an intellectual disability and a further amendment in 1988 to expand this to people with mental illnesses, acquired brain injuries and dementia.

The OPA has had carriage of the ITP program since this time, and while there have been a number of changes to its operation, and research and evaluation that recommends further changes to the role (McGuire, 2012; Victorian Government, 2013) in essence it has provided additional advocacy for this group in the police interview for over two decades. The program allows for people like family members or other advocates to act as ITPs, however it is the trained volunteer ITPs who are managed by the OPA that provide this advocacy on most occasions.

The OPA and CASAs have a formal protocol that outlines the ways they work together (OPA, 2012), and builds on and strengthens the long term relationship between OPA and CASAs. An ongoing issue raised by the research and evaluation of the ITP program has been the capacity of volunteers to provide advocacy in some particular cases, including sexual assault cases, with an OPA study finding that training of regular ITPs should include a component on sexual assault and should be conducted in collaboration with CASAs (McGuire, 2012).

In addition to the CASA/OPA protocol and the provision of training for ITPs on sexual assault, the MRR program has developed a formal approach to enable
SECASA Counsellor/ Advocates to act as ITPs for people with a cognitive impairment and/or communication difficulties who report to the police in the SECASA region. Forty SECASA Counsellor/ Advocates were trained by the OPA to be ITPs as part of the MRR program, and a further 15 in Gippsland which is outside the MRR program. While provision of a SECASA ITP is a formal part of the MRR program and an endorsed practice, it is still dependent on Police contacting SECASA to request a SECASA ITP rather than Police accessing the usual ITP referral process. The SECASA Counsellor Advocate may also initiate attendance as ITP for existing clients who decide they wish to make a police report. If SECASA do act as an ITP they perform the same role as an OPA ITP, however they also enable an immediate connection with SECASA and the potential for the client to have ongoing involvement with SECASA and the enhanced counselling and advocacy offered by the MRR program. It could also be argued that the expertise of SECASA Counsellor/ Advocates in dealing with sexual assault provide enhanced advocacy and support at the police interview. While the SECASA MRR model of providing trained CASA workers as ITPs has not been evaluated by OPA or the Police, the OPA ITP program are supportive of this approach.

The MRR program data indicates that a SECASA trained ITP was used in 11 cases from 2012 to 2014. Of the 108 MRR intakes, the assault was reported to the police in only 78 cases, including 10 historical cases and one case that had occurred overseas. There were also two cases noted in the program data where an attempt was made to use a SECASA trained ITP but none were available. Without access to the overall ITP data it is not possible to determine whether the SECASA ITPs were under-utilised in the two years of the MRR pilot program, nor is it possible to determine what factors might have influenced the use of OPA or SECASA ITPs in the relevant cases. These questions could be addressed by comparing ITP and MRR data and by interviewing SOCT police in individual cases to determine what influenced their decisions regarding allocation of an ITP.

Other justice outcomes
As noted above there have been three VOCAT outcomes for MRR clients. Of the 108 MRR intakes, other justice outcomes are recorded for 44 clients. Of these, convictions were reported in seven cases, but four of these were historical cases; in four cases reports were made but the case did not proceed, with a further seven that did not proceed because of insufficient evidence, and five where it was reported that the investigations were ongoing. In many of the cases the MRR data reports that the outcomes and progress of the cases was ‘unknown’.

There are therefore six clear and reported positive justice outcomes for the 108 MRR intakes over the two years of the pilot program. This figure does not necessarily represent the total number of outcomes and does not provide any indication of ‘qualitative’ outcomes for clients. Further research would need to be undertaken with clients to understand what influenced their decisions regarding interaction with the justice system, what their expectations or hopes were in
relation to ‘justice’, what outcomes they experienced, and whether there were other outcomes that were not reported. For example, a view was put by SMLS staff interviewed for this evaluation that the process of applying for compensation and having one’s application heard could have a therapeutic impact and some related feeling of ‘justice’ for some victims of crime.

A number of issues regarding access to justice for victims of sexual assault with a cognitive impairment have been raised through the MRR program. While SECASA and the SMLS worked together to ensure clients had access to advocacy, information and representation it is clear that there are other factors that impact on legal outcomes for these people. ‘Jasmine’s’ case study below illustrates some of these issues, particularly in relation to the question of proof or evidence of sexual assault, and the impact this had on what was possible regarding legal advocacy and outcomes for Jasmine. Without the opportunity to find out more from ‘Jasmine’ it is difficult to discuss whether the outcomes were sufficient for her.

What is clear from this case study is that the legal advocacy that was available to ‘Jasmine’ from her contact with the SMLSMRR worker was important. This dedicated legal service was able to work through what was available and possible with Jasmine to ensure that she had access to justice that was at least somewhat equal to other victims of sexual assault - a chance to be heard and believed by the legal service, some action in relation to her safety, and compensation for her experiences as a victim of crime regardless of the criminal justice outcomes for the alleged offender.

Jasmine was raped by her ex-partner in February 2012. The police did not proceed with their investigation due to insufficient evidence. SMLS provided support to Jasmine regarding an Intervention Order she wanted to obtain against her ex-partner. SMLS also made a VOCAT application for Jasmine but there were some issues with this. Jasmine attended a Directions Hearing where she was represented by a Barrister. The Tribunal didn’t appear to believe Jasmine had been raped. The Tribunal accepted at the Directions Hearing that Jasmine had been the victim of an Indecent Assault as opposed to Rape. Jasmine was awarded Victims of Crime compensation that included Special Financial Assistance, money to cover a holiday, costs for counselling and legal costs.

Given what is known about the likelihood of convictions in sexual assault cases, it could be argued that for Jasmine the justice outcomes she experienced were very
similar to those a person without a cognitive impairment who was a victim of sexual assault would experience, if they were able to access a service like that offered by the SMLS SE CASA clinic or able to pay for a similar service. Perhaps it can be argued that in this case the MRRR was able to ‘react the same bar’ of justice that is reached for many victims of sexual assault. That bar needs to be lifted for all victims - including for victims with a cognitive impairment.

**Impact of MRR - other sectors and the community**

Accessing sexual assault and legal services for victims of sexual assault with a cognitive impairment and/or communication difficulties is dependent on many factors. People who have experienced sexual assault need to be able to identify it as sexual assault, be able to disclose this to someone who will listen to them and believe them and/or find the relevant service to report to. The service or person needs to be able to ‘receive’ and respond to the victim who will have needs associated with their experience of the sexual assault and needs associated with their experience of disability. To do this, as is evident through the MRRR program, the service needs to identify the person as having a cognitive impairment and/or communication difficulty, access resources, information and skills to respond appropriately and collaborate with other services to get the outcome the person needs and wants.

For many people the first steps in this process are not possible; because they have not had access to information that enables them to understand their rights and recognise abuse. For others disclosing, saying to someone else that this happened is not possible because they have no way of ‘saying’ it and/or nobody to say it to who will listen to them or believe them, or to whom it is safe to say anything to - someone who is not the perpetrator or associated with them and their power. For many the relevant people or ‘services’ - families, advocates, neighbours, staff in disability services, community health and welfare organisations, the police and courts - are not capable of responding because they do not recognise the needs of the person or do not recognise the abuse. The MRRR program endeavoured to influence these related services and groups, but it is unclear to what extent this was achieved, apart from the service data that indicates families, disability services and the police made referrals to the SE CASA and/or SMLS, thereby indicating some level of awareness and response.

Some disability advocacy groups and organisations were involved in the program either on the reference group and/or were a part of the development of resources; however it is still the case that this program is not well promoted within the disability sector. Reference has been made to the program in some recent documents about responding to or preventing abuse of people with disabilities (see OPA IQUANA; NDS Zero Tolerance program) and the SE CASA project worker provided community education to disability organisations and presented at disability research conferences and other forums. While this raised the profile of
the program at these levels, it is not clear how aware people with cognitive impairments and/or communication difficulties in the South Eastern metropolitan region covered by SECASA and therefore the MRR program are of the program and how to access it.

More needs to be done by disability services and through disability advocacy and information services to ensure that this occurs, and more could be done to promote this program directly to people with cognitive impairments and/or communication difficulties as part of a suite of information on sexual abuse, relationship rights and safety. This kind of campaign is needed and could be included in work being undertaken by organisations like National Disability Services, the Office of the Public Advocate and the National Disability Insurance Agency in order to raise awareness about this issue directly with people with disabilities and service providers.

Other related services like the OPA, courts and the police had some direct involvement with the MRR, either through referrals, being on the reference group, training and/or collaborative work on resources developed in the program. Interviews with people from these services/sectors indicated that the closer they were involved with the program the more they knew about it and the more it influenced their work or impacted on their work. For the OPA, for example, there was close liaison to establish the CASA ITP training and they were represented on the reference group. Also for the police, their involvement and therefore their awareness of the program itself was through individual cases, with the police knowing the program more through the ITP role of CASA workers developed through the program. For the courts, their interface with the program was mainly through either VOCAT applications or other matters. In these cases the program was not named or known as a separate program.

The evaluation was not able to determine to what extent ‘knowledge of the program influenced any outcomes or processes within these services or sectors. For example, what is important in the justice system is how well the person who presents at court is represented as a result of the work that has been done with them by the legal service, CASA and/or the police to get them there and give them the best opportunity. For the 102 people who accessed the MRR program this was the enhanced counselling they received, the advocacy in the police interview or in other dealings with the police and, if they went through with a VOCAT application or sought other legal advocacy through SMLS, the degree to which this work prepared them for their interaction with the justice system. Again, the extent to which these services and supports worked for them can only truly be known by asking them. This is for future research and evaluation work on the MRR and similar programs and models but some evaluative feedback from clients could be built into the work of SECASA and SMLS for MRR clients.
Discussion

The MRR program was implemented in the way it was planned and for 102 people with a cognitive impairment and/or communication difficulties who were victims of sexual assault in the SECASA region there was access to counselling, advocacy and legal advocacy; it therefore could be argued that the program logic that underpinned this program was solid. The core components of the program — enhanced counselling and advocacy at a CASA, dedicated legal advocacy through a community legal service, access to brokerage funds for additional needs and access to a CASA ITP were all delivered through the MRR program. Having a program like MRR in a CASA and in a legal service provides a focus on this cohort of victims of sexual assault who it is recognised are at higher risk of abuse than the general population and other people with disabilities, and who it is recognised face significant barriers accessing the justice system. It ‘sines a lig t’ on tem collects important data about their experiences of abuse, focuses attention on their recovery needs and hones the skills of those involved in counselling and advocacy to meet these needs. It also engages ‘related’ services like disability services the police and the broader justice system in considering the needs of victims of sexual assault with a cognitive impairment and/or communication difficulties and their part in meeting these needs. Importantly, it does this with minimal additional resources (.6 FTE CASA and .2 FTE legal service).

Central to the quality of the program was the calibre of staff already in these services and the length and breadth of their expertise. SECASA has a long history of commitment to making its services accessible for people with disabilities and highly qualified and experienced staff whose practice was enhanced by the additional training and resourcing provided by the MRR project and project worker. The SMLS/SECASA clinic at SMLS, a longstanding, well organised and collaborative service was further resourced by a dedicated project worker who could focus on clients with a cognitive impairment and/or communication difficulties within this already ‘specialist’ legal clinic. These services and the staff involved in providing them were a strong foundation for the additional work of the MRR, while these components could be transferrable to other sites this would be subject to the allocation of funds and the development of processes to enhance what already exists in CASAs and community legal services.

Other CASAs across Victoria have established processes for working with people with disabilities, including three centres that have participated in the Living Safer Sexual Lives: Respectful Relationships program (Frawley et al., 2011) where CASA workers are trained to co-facilitate a sexuality and relationships program with peer educators with an intellectual disability and other community professionals for people with intellectual disabilities in their regions. The CASA network has also been delivering training on working with people with disabilities as part of their core training for many years. In the legal advocacy context, much work has been done through research and systemic advocacy to raise awareness of the issues
faced by people with disabilities in the justice system, and at the local level CASAs and legal practitioners work collaboratively to provide access to legal representation that meets the needs of a broad range of people, including people with cognitive impairment and/or communication difficulties. In addition, the ITP program is implemented across Victoria and CASA workers in other regions have already been trained by OPA to be ITPs in cases involving victims of sexual assault.

A further support to this work is the co-location of CASAs with SOCT units through Multi-Disciplinary Centres (MDCs). While there is no evidence from this evaluation that this model was any particular benefit to the program and the provision of legal services to people with cognitive impairments and/or communication difficulties, there are likely to be some benefits, in particular the capacity for knowledge about programs like MRR to be communicated easily to the police and promoted locally.

The MRR program is one example of how mainstream services can be enhanced to provide access to victims of sexual assault to people with a cognitive impairment and/or communication difficulties that is at least equal to the access available to others in the community. While there are challenges systemically in the disability and justice systems to recognise and adequately respond to the abuse of people with a cognitive impairment and/or communication difficulties, a service like MRR has achieved access to counselling, advocacy and legal representation for this group. Its implementation and the focus it is able to bring on the needs of this group also adds to the advocacy effort for the rights of people with disabilities to access services that are available to the broader community and to what ‘more’ is needed and can be provided to ensure their substantive equality.

This evaluation also finds there is much more to be done to achieve this equality, in particular in terms of supporting people with a cognitive impairment and/or communication difficulties to know their rights to safe and equal relationships and to safety in their homes and the community, to know about services they can self-refer to, and to advocate for ongoing enhancement of mainstream services to provide access that is effective. More is also needed to be known about the effectiveness of services and supports from the perspective of people with cognitive impairments and/or communication difficulties if services are to continue to develop to be truly accessible and effective for this group and other marginalised groups for whom the universal approach to access does not work well enough.

**Recommendations**

The MRR program continues in the South Eastern metropolitan region at SECASA and SMLS through continued funding of a project worker at SECASA and resources to support a legal position in the joint SECASA/SMLS clinic at SMLS.

SECASA and SMLS continue to collect and report data about people with cognitive impairments and/or communication difficulties and other disabilities.
Evaluative feedback be sought from these clients of SECASA and SMLS
That the MRR program be rolled out across Victoria by the CASA forum
Further work be undertaken with the disability service and disability
advocacy sector to promote the MRR in the South Eastern region and to
enhance access to sexual assault and associated legal services for victims of
sexual assault with disabilities as a program, service and advocacy issue
across Victoria
The findings of the MRR evaluation be used to identify and pursue further
research with the sexual assault, legal and disability sectors on outcomes of
services for people with cognitive impairments and/or communication
difficulties
References

ABS (2013) Personal Safety Survey


