

Royal Commission into Institutional Responses to Child Sexual Abuse:

Issues Paper 10: Advocacy and Support and Therapeutic Treatment Services

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1. Introduction

The Australian Psychological Society (APS) welcomes the opportunity to make a submission in response to Issues Paper 10: Advocacy and Support and Therapeutic Treatment Services. As the peak body for psychology, representing over 22,000 members, the APS is able to draw on the knowledge of a large number of researchers and practitioners whose expertise includes the application of psychological theory and knowledge to meet the needs of organisations, communities and individuals.

The APS commends the Royal Commission for their broad consultation on the provision of appropriate mechanisms for providing high quality support, advocacy and therapeutic treatment to victims and survivors in a way that meets their needs. While it is imperative to focus on promoting appropriate and effective treatment and support, the APS is mindful that this work should always be done in combination with prevention activities to minimise the risk of ongoing and future abuse. The Commission's work on promoting child safe environments is critical to address this issue.

The APS responded to several earlier Issues Papers including the Consultation Paper on Redress and Civil Litigation. The APS has approached Issues Paper 10 from a similar perspective to that espoused in those previous submissions. That is, this response utilises a psychological lens to focus on therapeutic treatment services aimed at reducing the signs and symptoms of poor psychological health in victims/survivors and improving their wellbeing and quality of life. The submission will address both current best practice in treatment services and ways to improve those services. While many psychologists are also involved in providing advocacy and support services to victims and survivors this will not be the primary focus of this submission.

2. Comments in response to specific questions on Issues Paper 10.

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?

It is not within the scope of this submission to provide a comprehensive critical review of the treatment literature. However we offer comment here on the evidence base for the use of psychological interventions in the treatment of many of the mental health problems that are commonly experienced by survivors¹, including Post Traumatic Stress Disorder (PTSD) and a range of

¹ See PTSD guidelines (ACPMH, 2013), NICE depression guidelines (<https://www.nice.org.uk/guidance/cg90>) and NICE anxiety guidelines (<https://www.nice.org.uk/guidance/qs53>)

depressive and anxiety disorders. There is also an evidence base for the use of psychological interventions for personality disorders.²

Although there is strong evidence for the treatment of specific disorders in isolation, the evidence base for the treatment of interpersonally-generated trauma that occurs during childhood and is complex in nature (as opposed to single incident trauma) is less well developed. Kezelman and Stavropoulos (2012) argue that there is a growing concern that the experience of such complex trauma can present comorbidly as more than one mental health disorder. Moreover, abuse that occurs repeatedly during childhood and within a trusted institutional environment is also likely to disrupt key development pathways in a number of areas of human development. Because the signs and symptoms for complex trauma vary greatly and often do not fit into discrete disorder(s), and there is so much variation in presentations, it is very difficult to construct treatment guidelines. This is particularly the case for culturally diverse populations, including indigenous Australians. In some cases it may be that some adaptation to standardised treatment protocols is required.

While there is insufficient high quality evidence (e.g., systematic reviews and randomised controlled trials) from which to construct robust treatment guidelines for complex trauma, there are a number of best practice guidelines for the delivery of services in an environment that can support individuals who have limited trust in organisations. The Adults Surviving Child Abuse (ASCA) Guidelines (Kezelman & Stavropoulos, 2012) provide a number of best practice principles for a trauma-centred framework to underpin treatment approaches for adults surviving child abuse:³

1. Provide a safe place for the client
2. Ensure client empowerment and collaboration
3. Communicate and sustain hope and respect
4. Facilitate disclosure without overwhelming the client
5. Be familiar with a number of different therapeutic tools and models
6. View symptoms as adaptations
7. Have a broad knowledge of trauma theory and provide the client with psycho-education
8. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies)
9. Teach clients to monitor their thoughts and responses
10. Teach clients interpersonal and assertiveness skills.

² See NHMRC borderline personality guidelines

(https://www.nhmrc.gov.au/files/nhmrc/publications/attachments/mh25_borderline_personality_guideline.pdf)

³ Available at <http://www.asca.org.au/WHAT-WE-DO/For-Health-Professionals/Resources-for-Health-Professionals/Best-Practice-Guidelines>

At an organisational level, it is worth noting that the call for a more trauma-informed approach to service delivery appears to be growing in acceptance in the mental health sector. Service provision that is oriented towards long-term recovery would also involve:

- replacement of the question *What is wrong with you?* with *What happened to you?*
- movement from an illness/symptom-based model to one of skills acquisition (particularly for children and young people)
- a shift from caretaking to collaborative ways of working
- the voice and participation of consumers should be at the core of all system activities

There is very little available evidence on what works in the treatment of children who have experienced sexual abuse within an institutional setting or context. Two types of therapy are commonly provided to support children and young people who have been sexually abused: talking therapies (including CBT, psychodynamic psychotherapy and counselling) and creative therapies (including play therapy, art therapy or drama therapy) (Allnock & Hynes, 2011). In their review of the evidence base for therapeutic services for sexually abused children and young people in the UK, Allnock and Hynes (2011) provide considerable evidence to support the effectiveness of CBT with child survivors. The review also identifies the following components as critical: high quality assessment, a child-centric approach, a strong therapeutic alliance, and having a safe carer involved, as well as culturally responsive and tailored care.

The 2011 review by Allnock and Hynes has been used to inform the development of a guide for therapeutic practitioners in the UK. This guide has in turn informed a new program 'Letting the Future In' which is currently being evaluated – a randomised controlled trial to see if a psychodynamic, attachment-based therapeutic approach helps sexually abused children and young people.⁴

A number of other guidelines and resources are also available to assist practitioners to work with children who have experienced child sexual abuse, although these are not specific to institutional abuse:

- International guidelines from UNICEF (2012) called 'Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings'⁵
- Standards of Practice for Victorian Centres Against Sexual Assault⁶
- Sexual assault services - DHS Child Protection Manual.⁷

⁴ <http://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/letting-the-future-in/letting-the-future-in-evidence-impact-and-evaluation/>

⁵ http://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf

⁶ <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/standards-of-practice-for-victorian-centres-against-sexual-assault>

⁷ http://www.dhs.vic.gov.au/cpmanual/practice-context/specialist-services-for-children-and-families/1086-sexual-assault-services-including-services-for-sexual-offenders?SQ_PAINT_LAYOUT_NAME=print_entire

- Australian Institute of Family Studies: Responding to children and young people’s disclosures of abuse.⁸

2. What does not work or can make things worse or be harmful for victims and survivors? What do victims and survivors need but not receive?

Service models

Given their experience with institutions, survivors need to feel in control of the treatment process. Provision of care by services that do not adopt a trauma-informed approach and/or by clinicians who do not work in a trauma-informed manner has the potential to be very distressing for survivors and can lead to them no longer engaging in treatment. And lack of early intervention or prematurely ceasing treatment can lead to a proliferation of negative coping strategies such as substance misuse that impact on the effectiveness of subsequent treatment.

There is a very real potential for survivors to be re-traumatised by well-meaning health professionals who have limited knowledge and expertise in working with clients who have experienced complex trauma. This is a significant issue for both child and adult survivors. Even therapists who have worked with clients who have experienced trauma may not be used to the unique contextual issues of child sexual assault experienced in an institutional setting and how this then can manifest for them in their adult life, or for child survivors seeking assistance.

Schools can inadvertently re-traumatise children and young people who have experienced abuse through not adequately responding to emotional regulation difficulties (e.g. the elevated child who cannot sit still). Implementing punitive measures which can result in further isolation/marginalisation serves to reinforce that they are bad or that something is wrong with them. For this reason it is imperative trauma training is extended to early education and school settings. There are some initiatives⁹ in this area but need to be expanded.

The Australian Child and Adolescent Trauma, Loss & Grief Network (ACATLGN) at ANU College of Medicine, Biology and Environments is a recognised authority in the area of trauma informed approaches for children. On the ACATLGN Schools and Trauma hub webpages, there are resources that have been brought together by experts in the field to support schools and staff in working with children experiencing grief, loss and trauma.¹⁰

⁸ Australian Institute of Family Studies Resource: *Responding to children and young people’s disclosures of abuse*, March 2015: <https://aifs.gov.au/cfca/publications/responding-children-and-young-people-s-disclosures-abu>

⁹ Australian Childhood Foundation SMART Training and Making a Space for Learning publication (<http://www.childhood.org.au/our-work/training-professionals>) and the Connections UnitingCare Pre School Field Officer (PSFO) program is an early intervention program that provides support and professional intervention to kindergartens to support the access and inclusion of children with additional needs and their families in their funded year of pre-school.

¹⁰ <http://earlytraumagrieff.anu.edu.au/resource-centre/schools-and-trauma>

It should be noted that while the focus of this submission is on treatment, many survivors will need a range of other supports and services, beyond treatment for mental and physical symptoms. These services can include assistance with housing, employment and parenting, and some survivors will need to access welfare support through agencies such as Centrelink. Dealing with such agencies can be particularly challenging for individuals who have limited trust in governments and bureaucracies. Moreover, these services often struggle to deliver trauma-informed services and thus have the potential to re-traumatise survivors and contribute to non-help seeking behaviour.

A cautionary note about PTSD

There is a popular assumption that PTSD is the most common clinical presentation in the aftermath of sexual abuse, particularly in childhood. It is typically seen in exposure to threatened death or sexual violence. But even though sexual abuse is no doubt traumatic, not all cases involve overt violence, and much abuse in institutional settings is chronic rather than episodic, involving a process of grooming and/or multiple incidents over time. Such abuse in childhood may involve secrecy, shame and embarrassment more than shock, terror or pain. Survivors' responses in such cases may be quite different from the arousal, intrusion and avoidance symptoms that characterise PTSD.

Employing a classical PTSD approach therefore falls short of fully describing the outcomes of child sexual abuse, in particular the betrayal of trust and associated interpersonal difficulties. PTSD may be one of multiple manifestations (such as persistent depressive disorder, personality disorder, or substance abuse) which all pertain to underlying complex trauma. People with underlying complex trauma can present with multiple diagnoses, a history of confused diagnoses, or shifting presentations, each of which cannot be understood outside of the traumatic context. These diagnoses stack up and can be damaging to self-concept, particularly if a survivor already feels they are damaged, and if they are not accompanied by the appropriate evidence-based treatment and trauma-focussed support.

3. What helps or facilitates access so victims and survivors receive what they need? What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?

Barriers to access

It is important to note some of the factors that might underpin help-seeking behaviour among survivors. Many survivors will struggle to engage with services because of the very nature of the medical and welfare service model. As a result of their experiences, many survivors will have limited trust in governments and bureaucracies, yet negotiating these systems is required in order to obtain help. This can involve having to repeatedly re-tell their story, sometimes to administrative staff and health professionals who have limited knowledge and

skills in working in a trauma-informed way with individuals who have experienced complex trauma. The feedback from APS members who work in specialist sexual assault services (both in government and non-government sectors) is that demand greatly exceeds supply and waiting lists can be long, particularly for adult survivors.

It can thus take considerable persistence and effective coping skills in order to obtain the support and treatment that one needs. As a result of the impact of their experiences on their psychological well-being, many survivors will struggle to sustain help-seeking behaviour in the face of such hurdles.

There are multiple barriers to appropriate psychological service delivery under the MBS:

- The requirement for referral through a medical practitioner (usually a GP) will often require a survivor to re-tell their story again to a health professional who may not be skilled in trauma-informed care.
- The requirement for a mental health diagnosis in order to receive treatment. In the absence of a diagnosis, psychological interventions for abuse-related issues (e.g., relationship or parenting issues) are not accessible under the MBS.
- The limitation of 10 sessions per year is less than best practice in the treatment of many complex and comorbid mental health issues that are experienced by survivors. There is no simple or robust answer to the question of how many sessions survivors should be able to access. Survivors may present for counselling and psychological care at various points in their life journey and in their readiness to undertake intensive therapy, hence there is no benchmark for length of treatment.

Many of the manifestations of a history of sexual abuse do not classically meet diagnostic criteria for a DSM or ICD disorder, but do cause a significant amount of social, occupational and interpersonal impairment. For example, among the most frequently encountered counselling needs of survivors are relationship issues; but in the absence of a mental health diagnosis, these needs cannot be met under the Medical Benefits Scheme (MBS). Nor will they be addressed by most mental health services or AOD services. There are thus very few affordable options for survivors to access relationship-specific services.

Factors that facilitate access

Accessible and trustworthy service provision

Institutional child sexual abuse is an interpersonal trauma central to which is a betrayal of trust. In order to develop trust, services need to value the experience of an attachment based consistent therapeutic relationship. Accordingly, services need to ensure that survivors, particularly children and young people, do not experience multiple changes in workers/counsellors.

The ability of mainstream services such as mental health, alcohol and other drugs, general practice, welfare and emergency departments to identify and appropriately respond to the needs of survivors should be strengthened. Survivors frequently come into contact with these services. This is an important window of opportunity to provide a safe, trauma-informed service and to connect survivors with more specialised care.

Some survivors may have multiple life problems and require considerable support in order to effectively engage with services. It is important to ensure that service models are able to be sufficiently flexible to incorporate frequent appointment reminders and accommodate potentially high non-attendance rates. For Aboriginal and Torres Strait islander survivors, as well as for other cultural groups who may be unfamiliar or uncomfortable with medical-model service delivery, waiting lists and appointment- or clinic-based models may need to be dispensed with altogether.

It is also clear that becoming a parent can be a challenging time for both male and female survivors. Thus, health practitioners involved in the care of parents during the perinatal period should also receive training in identifying and responding to survivors' needs. This will include a range of clinicians including general practitioners, obstetricians, midwives and early childhood nurses.

Where the survivor is a child, training should include skills and approaches to assist the child's family to navigate what is the best support and assistance available for a child. The Australian Government Department of Health recently funded the APS to develop and deliver a program to support health professionals working in mainstream health services who may encounter or deliver services to people who have been affected by Forced Adoption policies and practices in Australia. A similar approach is required to up-skill workers in mainstream health and welfare services that frequently come into contact with abuse survivors.

A major facilitator is the availability of care by clinicians experienced in delivering evidence-based, trauma-informed services to clients with a history of complex trauma. This is important to avoid inadvertently fostering further lack of trust in the 'system' and potentially re-traumatising survivors. It is currently very difficult for survivors to identify such clinicians in both the public and private sectors. It should not be up to survivors to have to navigate the system to locate clinicians on their own.

Suggested improvements to MBS psychological services

- Removal of the requirement for a mental health diagnosis for survivors.
- Removal of the requirement to 'tell the story' to a medical practitioner, not all of whom are trauma-informed, in the 'hope of gaining a diagnosis' in order to obtain psychological treatment.
- A major barrier to care for many survivors is the gap fee under the MBS for psychology services. It would be of assistance to survivors if there was adequate remuneration of psychological services provided to survivors such that psychologists were not forced to claim a gap fee. This

is required in order to provide survivors with access to appropriate redress services at no cost. The higher remuneration should only be applicable to providers with demonstrated competencies in working with complex trauma.

- A specific item number for group psycho-education (with no gap fee) is also warranted given the evidence of the effectiveness of this modality for survivors. Trauma education, self-care and safety strategies can be effectively provided in group settings.
- Experienced practitioners suggest that there will be times where long-term treatment is required and other times when therapy is more short-term (e.g., up to 20 sessions) and contained around a particular trigger or issue. On this basis, the APS supports the principle of no fixed limits on the number of services provided to a survivor.
- Existing government and non-government organisations that provide specialist services must be able to extend their capacity, for example by being able to claim the appropriate Medicare rebates.

While the APS supports the principle of 'no predetermined limits' on the number and length of services provided to a survivor, it is important to ensure that counselling and treatment services are regularly reviewed to ensure that goals are being met and progress is being made. The objectives for these services must be clear to both the service provider and the survivor. Unlimited and unfocused treatment is potentially harmful to the client, and of course, also represents poor use of limited resources. The APS suggests blocks of counselling sessions (e.g., 10 sessions) for which goals are jointly established and progress against these goals regularly reviewed in a way that is acceptable to survivors.

It is acknowledged that at the beginning of some sets of care, the objective of treatment may be as simple as establishing an effective therapeutic alliance, with more symptom-specific goals developed over time. It is recommended that the review process include a mix of joint practitioner-client review and occasional external review. The process surrounding the independent review should be developed with input from survivors so that it avoids jeopardising the therapeutic relationship or re-traumatisation; it is nevertheless a vital quality control strategy and an important protection for survivors. Input from child survivors to the review process will be relative to their age and stage of development. With child survivors it would also be important to support parental or guardian input where applicable.

4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors? How could these services be shaped so they better respond to secondary victims?

In general, it is very difficult for secondary victims and survivors to obtain treatment in the community, particularly early intervention (that is, prior to the development of a mental health diagnosis).

Access to psychological care in the community is currently available through Medicare, which could provide some services for families and caregivers. However, to access these services the client is required to have a mental health diagnosis as assessed by a medical practitioner (usually a general practitioner). Many family members would benefit from psychological care even though they do not have a diagnosed mental illness; for example, counselling could assist family members experiencing difficult relationships with the survivor and help them cope with challenging behaviours such as substance misuse. The provision of such therapy has the potential to be of significant benefit to the survivor and is vitally important for child survivors and their families, in order that a child receive the best possible support.

The other major potential sources of support and treatment for secondary victims are specialist sexual assault services. However, these services often have limited resources and struggle to adequately meet the needs of survivors; understandably, many specialist services prioritise survivors ahead of secondary victims.

Services and programs provided by Aboriginal Community-Controlled Health Organisations typically involve family, kinship and community networks as appropriate. This holistic framework may provide a useful model for the development of a more effective response to both Indigenous and non-Indigenous survivors of institutional abuse which incorporates the needs of secondary victims and survivors.

The Royal Commission could consider recommending that the requirement for a mental health diagnosis in order to access psychological services under the Medical Benefits Scheme be removed for direct family members and caregivers of adult and child survivors.

Topic B: Diverse victims and survivors

- 1. What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups? What types of models and approaches are used to address the particular needs of these populations?**

The Victorian Centres Against Sexual Assault (CASA) Standards of Practice¹¹, state that a CASA "will develop policies and procedures to implement cultural safety across the agency including:

¹¹ Standards of Practice for Victorian Centres Against Sexual Assault:
http://www.dhs.vic.gov.au/_data/assets/pdf_file/0008/581462/casa-forum-standards-nov2008.pdf

- Access to multilingual information;
- Protocol with linguistic services;
- Recognition of the particular needs of cultural groups and individuals;
- Consultation with newly arrived groups.” (p.34)

Standard 3.4 states that “Strategic cultural planning is incorporated within the agencies’ service planning and evaluation to improve service provision and accessibility for cultural groups. Policies aimed at improving cultural equity and accessibility inform the immediate and long term objectives of the CASA”. (p.35)

Victims and survivors from diverse backgrounds will also need access to a range of services including crisis services, outreach services, family therapy services, domestic violence services, dual diagnosis, support groups and telephone/online support. There is no guarantee that such services will be culturally appropriate.

2. How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?

Research is required in this area to better understand if survivors from diverse communities seek treatment, how they access treatment, and what they report as helpful/unhelpful. However, promoting help-seeking in the absence of accessible, culturally appropriate services and programs risks raising false expectations at best, and doing more harm than good at worst.

Since the Royal Commission Into Aboriginal Deaths in Custody (1987), a number of inquiries and reports have drawn attention to the need to provide mental health services that: are informed by Indigenous concepts of ‘social and emotional well-being’; recognise the impact of colonisation on individuals, families and communities; reflect and integrate local cultural practices; and address community identified needs; rather than clinical mental health services which emphasise *individual* pathology. And it should be remembered that the cultural diversity within Aboriginal Australia and between Aboriginal and Torres Strait Islander peoples means it is not possible to identify ‘what works’ in one community/population and to ‘do the same’ elsewhere: one size does not fit all.

The APS fully supports the recommendations contained in the submission by the Coalition of Aboriginal Services (Victoria) in response to the Royal Commission’s Consultation paper: Redress and Civil Litigation in March 2015:

There was broad agreement that individual preference needs to be considered as not all survivors will want mainstream counselling, and not all survivors will opt for healing programs with a strong Aboriginal and Torres Strait Islander focus. However, overall, participants expressed the importance of holistic healing and for the process to be empowering, not just for the individual but also for family and community. Such holistic approaches to healing have proven to be increasingly successful in

engaging with the Aboriginal and Torres Strait Islander community(s) and meeting growing needs... There was a strong view that cultural healing programs contribute to individual healing and wellbeing and in turn contributes to the overall wellbeing of family and community. Participants felt that it was important not only to focus on counselling that targeted distress and trauma (i.e., symptoms management and reduction), but equally important to have strength based programs that focussed on improving self-worth and cultural wellbeing and identity. This is particularly important because Aboriginal survivors from institutions may experience two layers of trauma - interpersonal trauma such as sexual abuse combined with loss of connection to culture and heritage. Cultural activities and cultural camps can greatly assist in enhancing self-esteem and strengthening identity. (Submission 019, pp. 5-6).

Agencies and practitioners need to commit to all forms of diversity, including diversity of coping mechanisms, as most contemporary theories and practices are grounded in western assumptions, yet most of the world differs from mainstream western culture.

Principles of cultural safety and cultural responsiveness need to be embedded into service provision. This should include (but is not restricted to) having a policy to promote access to interpreters as required. Foundation House in Melbourne has produced a report outlining recommendations for promoting engagement of interpreters in Victorian health services.¹²

According to the clinical experience of an APS member, people from Middle-Eastern and South Asian communities often initially seek treatment from a GP for physical/behavioural symptoms (e.g., heart rate or difficulty sleeping). The GP might conduct a range of tests and when no physical cause is identified, might encourage a referral to a psychologist for assessment. If the client accepts the referral, the client might disclose an abuse history only after a significant period of relationship building. Given the stigma and shame that can exist for people from diverse communities around seeking help for mental health issues, consideration could be given to:

- rolling out training for community/religious leaders to help triage community members to appropriate supports
- developing online multi-media resources providing psychoeducation (what is abuse and its emotional and behavioural impact) and referral/treatment information in multiple languages.

In a UK review of therapeutic services for children and young people who have experienced child sexual abuse, it was noted that children from black and ethnic minority (BME) groups and children with disabilities were often overlooked in research (Allnock & Hynes, 2011). From the evidence available, the authors suggested that the following should be taken into consideration when working with children from BME communities: different cultural beliefs, particularly when

¹² <http://www.foundationhouse.org.au/promoting-engagement-interpreters-victorian-health-services/>

practising CBT, treatment may take place in parallel with traditional non-scientific approaches, the roles of the family and extended community, and spirituality or religion. For children with disabilities, creative therapies were identified as being potentially relevant.

3. What would better help victims and survivors in correctional institutions and upon release?

Incarceration arguably has psychological costs in terms of increased mental illness and likelihood of recidivism. Many groups in prison have suffered violence, trauma and grief and have significant mental health concerns. Some of these will be survivors of child sexual abuse that took place in institutional contexts. There is concern that whilst incarcerated, the needs of both adult or child survivors will not be met.¹³ This is especially the case for vulnerable groups of survivors in society such as women, Indigenous people, migrant and refugee communities, young and elderly populations, disabled and the mentally ill. And prisoners who have experienced abuse in institutional settings as children are likely to be particularly at risk of retraumatisation when they face being confined once again as youth or adults in a detention or prison setting.

The Royal Commission could recommend that the Commonwealth and State/Territory Governments:

- review the appropriateness of incarceration of survivors for minor crimes, particularly for disadvantaged or more vulnerable groups, and for minors
- consider alternatives to incarceration so that survivors can be cared for within their communities, at lower cost, and at overall benefit to them and society
- ensure that adult survivors incarcerated for more serious crimes are supported with appropriate counselling and psychological care, which may include both individual and group treatment approaches
- assess the type of advocacy, support and therapeutic services that will be required for survivors post release from incarceration.

Topic C: Geographic considerations

1. What challenges do service providers face when trying to respond to the needs of victims and survivors outside metropolitan areas (e.g. those living in regional, rural or remote areas)?

The access difficulties described above confronting most sexual abuse survivors are likely to be magnified for those living in rural and remote areas. For example, it is harder to find a clinician experienced in delivering best practice

¹³ This applies to children over 10 years old. For example, in Victoria, a child/young person can be in detention if found guilty of a criminal offence and sentenced to a youth detention centre - they may also be a victim of child sexual abuse. The age of criminal responsibility may vary between states/territories but the same concern applies to young people in youth detention/incarceration who may also be survivors of child sexual abuse.

psychological services to adult and child survivors in rural regions. It is also likely that the problems associated with staff in health organisations and government departments having limited knowledge and skills in the delivery of trauma-informed care are even more acute in rural and remote Australia. This can be particularly the case in more remote emergency departments and clinics that are often staffed by locums or agency personnel.

Service providers themselves face a range of challenges when trying to respond to the needs of victims and survivors outside metropolitan areas. These include:

- Limited access to other professionals from a range of disciplines
- Professionals may not be skilled in dealing with complex trauma
- Complexities associated with small communities
- Stigma
- Distance
- Isolation
- Flexibility of services (telephone, outreach).

Developing the capacity of the rural and remote psychology workforce is also a challenge. Like all allied health workforces, psychologists are under-represented in rural and remote Australia.

2. What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?

The report of the National Review of Mental Health Programmes and Services (National Mental Health Commission, 2014) flagged the mental health workforce issues in rural and remote Australia. Geographical mal-distribution is an issue for all sectors of this workforce, including psychologists. The psychology workforce has not received government incentives for rural practice or support for rural training pipelines that have been effective for other health professions (e.g., medical practitioners and pharmacists). The implementation of strategies to grow the capacity of the rural psychology workforce is central to being able to meet the treatment needs of survivors and secondary victims. These strategies should be drawn from what has worked for other health professions, such as:

- targeted scholarships for rural students to undertake professional training in psychology and support for rural graduates to complete their internship in rural and remote Australia.
- financial and relocation incentives and support for professional development and mentoring of rural psychologists.

The difficulty in operating a financially viable private practice in rural and remote Australia has influenced the capacity of this workforce and hence access to psychological services under the MBS in these regions. Strategies that could improve access include:

- placing a loading on Better Access services in rural and remote Australia (as exists for GPs) to encourage psychologists to practice outside metropolitan regions.
- allowing the delivery of psychological services to survivors by telehealth under the MBS, as occurs for psychiatry.
- providing training in best practice interventions for sexual assault and trauma-informed service delivery to rural practitioners.

There has been considerable interest in eTherapy for many mental health issues as an innovative solution to rural workforce issues. Research provides some support for eTherapy and it may offer an option for some survivors and secondary victims. However, for many survivors residing in rural locations who have complex needs and multiple comorbidities, eTherapy is unlikely to be an adequate treatment option.

What may be of assistance to improve the quality and acceptability of services to survivors in rural regions is the provision of a supervision network for rural and remote psychologists (and other mental health clinicians) working with survivors so they can access the expertise of experienced clinicians for complex cases. The APS has the capacity to operate a supervision network and to deliver high quality CPD to rural practitioners using online modalities. The Department of Health and Ageing funded the APS to roll-out online training to practitioners delivering child mental health services through ATAPS and a similar model could be used to provide training to rural practitioners in best practice service responses to child sexual abuse.

Topic D: Service system issues

- 1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?**

The definition of therapeutic treatment is sufficient, but we would like to emphasise the importance of bringing about measurable or demonstrable change in outcomes in terms of improved wellbeing and quality of life.

- 2. Given the range of services victims and survivors might need and use, what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need? What type of service models help victims and survivors to receive the support they need?**

See previous response to Question A.3

As indicated in our response to Topic A, a trauma-informed approach is essential to assisting survivors to receive the support they need and to minimise the risk of re-traumatisation. Trauma-informed interventions occur at two levels: trauma-specific interventions and trauma-informed models of care (Wall, Higgins & Hunter, in press). Wall et al. argue that trauma-specific services are best delivered as part of a trauma-informed system of care operating within a trauma-aware organisational context. However, there are several challenges to implementing systemic change, such as the lack of consistency around what it means to be trauma-informed, the task of facilitating such complex change, and the difficulty in evaluating its effectiveness. Substance Abuse and Mental Health Services Administration's (SAMHSA, 2014) *Concept of trauma and guidance for a trauma-informed approach* could be an important resource in the adoption of a more consistent approach and understanding of trauma-informed care.

Designing a trauma-informed service model that is specifically tailored to the needs of survivors of child sexual abuse in institutional settings and contexts would need to incorporate attention to:

- referral pathways
- a no wrong door approach
- funding for advocacy
- funding for support services
- easier access to specialist therapeutic services
- community awareness programs
- services that talk to each other, and
- the infrastructure required to support all of the above features.

Moreover, given the evidence that child sexual abuse is a strong risk factor for a range of separate and comorbid mental health problems (including depressive and anxiety disorders, PTSD and complex PTSD, personality disorders, and substance abuse), there is a clear need for an investment in resources to support the public mental health system. Many of these mental health conditions are complex and many individual survivors have multiple conditions (comorbidity). The nature of these disorders is that they can fluctuate over time, with periods of sometimes severe exacerbation and other periods of relative stability. When very unwell, individuals can need extensive support that is best provided in the public system. The public system currently struggles to provide intensive interventions of the type that might be needed by survivors, especially in outer metropolitan and rural/remote areas (e.g., Dialectical Behaviour Therapy for Borderline Personality Disorder delivered in combined individual and group packages of care). There thus needs to be considerable investment in the public mental health and alcohol and other drug sectors to increase capacity to offer more than just crisis management, and to enable them to deliver trauma-informed services that take account of rather than exclude comorbidities.

There is also clear evidence that experiencing abuse, particularly in the absence of good support at the time and later, can have detrimental impacts in the full

range of life domains and can negatively shape opportunities, experiences and outcomes across many of these areas. Therefore it is important to look beyond mental health services only, and ensure that people who have experienced child sexual abuse can access a whole range of coordinated services and support – including those related to housing, finances, physical health, education/ occupation, relationship building, skills and interest development.

3. How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?

It is important to note that having the right capabilities to work with this cohort (which will be different when working with adult or child survivors) means that practitioners must have the appropriate knowledge, skills, and experience to work competently with complex trauma, and must be organisationally/ systemically supported themselves in undertaking that work. As a minimum, health professionals working with survivors should be experienced in comprehensive assessment, case formulation, diagnosis and treatment for traumatised populations, and should meet the following criteria:

- Five years post-registration or post-qualification
- Demonstrated knowledge, experience and competence in working with clients with complex trauma with an evidenced-based approach
- Familiarity with the Adults Surviving Child Abuse Practice Guidelines (Kezelman & Stavropoulos, 2012) and where applicable, the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (Australian Centre for Posttraumatic Mental Health, 2013).

Health professionals need to be both culturally safe and trauma informed, and therefore need to be properly equipped with culturally appropriate as well as trauma-specific training.

Working with child survivors requires particular skills and competencies. Many practitioners experienced with working with adults may not wish to work with child survivors nor have the requisite knowledge and competencies. This must be considered when developing an appropriate workforce.

Survivors benefit from having a choice of service delivery model and evidence-based treatment, and the flexibility when needed for a different approach. Currently, this is not always possible in Australia. As previously stated, effective trauma-informed interventions are likely to occur in trauma-informed systems of care. Central to this is the nature and effectiveness of staff support systems that maintain healthy workers and teams. It is imperative that organisations, teams, and practitioners:

- understand vicarious trauma (development, symptoms; impact on the workplace)

- implement prevention and response strategies to vicarious trauma (supervision, reflective practice, organisational responses, and self-care plans).

The APS supports the development of an accreditation process that could assist survivors to access competently delivered counselling and psychological care in the community. The APS would be pleased to work with other professional associations and specialist services to develop a competency-based accreditation process and maintain a database of appropriately qualified health professionals to work with adult and/or child survivors. The APS currently operates a 'Find a Psychologist' service and holds lists of providers for particular government programs. The APS also has the capacity and experience to deliver national online training, practice certificates and webinars that might support an accreditation process.

Topic E: Evidence and promising practice

As indicated in our response to Question A.1, it is not within the scope of this submission to provide a comprehensive critical review of the treatment literature. However, it is noteworthy that:

- there is a lack of high quality evidence regarding the effectiveness of treatment for this specific population group, particularly where there are indications of complex trauma and comorbidity in presenting symptoms
- there is much literature describing the effectiveness of psychological therapies for specific clinical disorders and personality disorders. For a comprehensive review of the literature for a number of disorders, refer to *Evidence-based Psychological Interventions: A Literature Review* (APS, 2010).
- it is difficult to carry out what is considered high quality research, such as that involving randomised controlled trials(RCTs), with this specific population group due to the range and complexity of possible presentations and the ethical constraints of assigning people with urgent needs to a control group, or to treatment that is by definition as yet unproven.
- while it may not be possible to conduct RCTs in the field of complex trauma in order to identify the gold standard of treatment, we do know that skilled practitioners who can competently assess, case formulate and work collaboratively will have a range of established therapies available to them that may be beneficial for this group of people (e.g. Schema Therapy, Emotion focused therapy, Psychodynamic therapy).

3. Conclusions

Given the contention around the relative efficacy of different approaches to treating complex trauma, the APS recommends commissioning an independent

and systematic review of the literature. This submission has focused on therapeutic treatment services aimed at reducing the symptoms of poor psychological health in victims/survivors and improving their wellbeing and quality of life. The submission has addressed both current best practice in treatment services and ways to improve those services.

References (additional references are included as footnotes)

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