



## drummond street services

### Response to Royal Commission Issues Paper 10

### Advocacy and Support and Therapeutic Treatment Services

#### Topic A: Victim and survivor needs and unmet needs

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

- Services that are of therapeutic value to clients, where value is defined as something the client would experience as beneficial and assisting them to move towards their goals for recovery. These goals are formulated in collaboration with the practitioner as an element of engagement and assessment. What encompasses wellbeing is what the person as an individual within the context of culture and the system they live in perceives wellbeing to be.
- Services need to be able to respond to the diversity of client needs, in particular have sufficient resource and flexible deployment of that resource to match the intensity, length of involvement, and the nature of services required (e.g., intake information, support and referral, engagement issues, long-term therapeutic support).
- Practice Principles
  - Transparency with clients about the limits and boundaries of services. However, boundaries need to be flexible so as to enable clients to define the nature of the service they receive
  - We recognise that power dynamics are in operation and we explore with client's how they see power being shared.
  - We respond to where clients are at. Some clients want and ask for more intense case management whereas others want the opportunity to access support from us where they think they may need it and still others only want the opportunity to debrief their contact with these systems, within the context of a counselling session. The prioritisation of present and current health risks clients are managing, such as housing, pregnancy etc.
  - Clients are often triggered by issues around trust, being taken seriously, what they construe as respectful interactions and the trauma reactions when these are challenged, need to be managed.
  - Clients want to be assured of a consistent service from workers who won't abandon them or organisations that won't reject them.
  - Advocates and supporters need to operate under the premise of "say what you do and do what you say" at all times. Clients need this approach to begin to consider that the worker/organisation/system with which they are interacting, can be seen as trustworthy
  - When trauma reactions are triggered they are usually highly elevated and may be at times disproportionate to the external event or incident outside of themselves that has triggered the reaction. This is not due to the client

- themselves but as an understandable effect of their traumatic experiences in childhood.
- We also recognise the importance of “fit” between the practitioner and the client. If the match isn’t right then we reallocate to allow a new therapeutic relationship to flourish.
- Approach
  - The capacity to provide telephone support is needed, not only to enable anonymity for those living interstate to access a service at some distance from them, but also for those living nearby, if there are needs between scheduled appointments, or they feel unable to attend a face-to-face session on the day.
  - We do a whole of family assessment if the trauma is impacting on family relationships or the family system and we act where the family feels they need assistance. A whole-of-family approach to service delivery is required for example, to early intervene with trajectories of children relating to trans-generational impacts.
- Interventions
  - Promoting self-agency involving a graduated stepping into agency and personal power i.e., assisting them to navigate systems and hierarchies like government depts., medical and allied health, legal and housing systems.
  - When offering support – choice is vital. The need for a flexible service which is able to respond to the changing and at times highly intensive, case-management needs such as accessing information or services and coordination of care, as well as the ongoing individual therapeutic work.
  - In order to maximise access it’s important to be able to offer centre-based and outreach appointments, including meeting at community settings or in homes,
  - Psychoeducation around trauma and its impacts of trauma on physiology/stress response and functioning, an opportunity to explore and understand the many levels of impacts of the abuse/trauma has had on their lives, and of those around them.
  - Coping in the day to day, strategies to enhance functioning i.e. general life skills as well as strategies to assist modulating and regulating trauma reactions
  - Counselling
  - Normalizing experiences. Clients in isolation draw great value in being linked into supportive systems to reduce social isolation and disconnection and to enhance their sense of feeling heard and believed.
- The following are comments from clients themselves, gathered in the course of receiving feedback from clients about their engagement with drummond street’s RCSSS indicate the need for services to take the following into account:
  - the need for a long-term recovery and self-management focus for some (commenced/continued)

- the chronic/long-term nature of support needs (at times of deterioration, for example)
- the mental health service system limits to providing for the needs of this group
- explain things well, go over the process, with care taken
- flexibility in location of service- being able to outreach to or close to their home ("come to me!")
- take into account functioning in support (such as ABI, poor sleep)
- the perceived benefits of disclosure and support to articulate/form narrative about what happened
- the benefits of addressing the broader issues in their lives
- professionals' characteristics to include commitment/patience/compassion/sincere/ expertise for trust to be built;
- facilitated/peer social/recreational opportunities to reduce social isolation and increase sense of wellbeing;
- increased program promotion within the community, e.g. via business cards or paper ads to make it more accessible;
- clear information about the service offered at the outset
- Attention to worker/client matching- i.e. knowledgeable re service, RC process etc. – i.e., perhaps to key RCSS worker for RC information/support and transfer to other for ongoing needs
- Ability to explain complex nature of emotional issues/impacts related to experiences, and recovery processes
- A caring, nurturing and informative process
- Practical/financial barriers to participation- e.g., fuel to attend sessions

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?

- Attending a service – including accessing RCSS - is often a triggering experience in itself; failing to account for this may lead to misunderstanding survivor experiences at the times they present for services. Clients are often triggered by issues around trust, being taken seriously, what they construe as respectful interactions and the trauma reactions when these are challenged, need to be managed.
- Desire for privacy – systems need to be flexible in the way that clients enter the service. Services need to have policy and procedures for managing circumstances where clients request that services not take notes of discussions, that they not sign documents such as consents, not share personal information relevant to assessment/duty of care. Services need to balance respect for client requests and organisational risks; e.g., by documenting why standard processes are not able to be completed, use of pseudonym. Identifying the way in which the relationship between client and organisation is documented needs to be negotiated with the client.
- The need for sensitivity and a focus on engagement and trust building at all times, as well as a 'crisis'/distressed or 'scattered'/disorganised thought presentation by some, can make standard assessment and goal-setting processes more difficult to achieve - services that do not move at the clients pace risk client disengagement



- Failure to manage expectations about the way that services operate in promoting client's movement towards recovery may exacerbate mistrust
- Clients having experiences of telling their story multiple times. Clients not feeling that they can share their experiences at all because of working with systems that they can't trust. These issues bring a myriad of complexities such as clients feeling disenfranchised and "having fallen through the cracks"
- If a client feels lost in the system or in the organizational structure, this can exacerbate feelings of invisibility and powerlessness. This is reinforced often when they speak to different parts of an organisation or system.
- Barriers: mobility, finances, disability, worker availability, worker capacity.
- Current mental health services- trauma informed care and practice is still not front and centre of these services, and they continue to be harmful and not therapeutic for many.
- Survivors need practitioners with Increased knowledge and skills that enable services to treat highly vulnerable and complex clients as survivors of abuse/trauma, with therapeutic needs placed as the highest priority, and the wrapping of services/integration of services around clients, rather than expecting these clients to navigate and coordinate their own services and experience at times pathologising or punitive over-medicalised approaches. The need for client-led, strengths-based and optimistic recovery approaches to service delivery is essential.
- As is the case for many vulnerable people and families, service systems that are integrated and place the client at the centre of pathways and systems are far more likely to be experienced by clients as sensitive to their particular needs and enable client autonomy. Connections between advocacy/support/therapeutic services and other systems such as housing, financial, education, training and employment will strengthen client capacity to access and sustain engagement with key services and pathways to recovery.
- Lack of understanding/appropriate responses by services of mental health symptomology and physical appearance. E.g.,: experiences with police and hospital/in-patient units as institutional abuse; employment agency being ill-equipped to support someone with severe mental illness; counsellors trying to solve the problem rather than giving practical strategies to protect and support self; costs of helpful private practitioner prohibitive; medical records going missing from GP; not listened to by private practitioner who was more interested in explaining the efficacy of their modality rather than exploring her needs and goals

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?

- Given that survivors have had abusive experiences within institutions, flexibility around the focus of advocacy needs to be there to ensure that clients feel respected, empowered in the process and that their dignity is maintained. Services need operate with a no wrong door philosophy, being transparent about the reach of their practitioners skills and prepared to facilitate and negotiate the involvement of other agency and community resources where required. The extent to which services advocate from behind, beside or in front of clients is determined in a

- collaborative, respectful ongoing dialogue between service and client in a way that acknowledges the dynamic nature to recovery.
- Clients having choice about the pace at which they enter a service and the pathway followed into the service is vital.
- There is a need for the supplementation of existing specialist services (not RCCS) to enable responsive and intensive services as required, while also see the need for a built capacity to support survivors within our broader service system; mental health, AOD, homelessness and family services, as well as primary (physical) health services that are trauma-informed.
- Some adults who experienced childhood sexual and other forms of abuse within institutions have supportive families to protect and support their recovery, while others have no such support available, and others experienced direct abuse within their own families. Family protective factors no doubt influence impacts and recovery trajectories, hence, it's important that existing and new services adopt family-aware practice and even family-inclusive practice within this work.
- Clients ceasing without notice may relate to difficulty in managing their relationships/support needs OR the practitioner not being adequately attuned to their needs at the time or not providing adequate avenues for client feedback and direction of the service
- Other info suggests the challenge of coming to sessions and the possibility of increased mental health symptoms as a result of coming need to be managed. Therefore a focus of the work could be on this - strategies to make sessions manageable and positive. Possibly greater need for client feedback session by session – asking “are we on track?”, “how are you experiencing the sessions” etc.

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 terms of responding to secondary victims we need to ensure that secondary victims feel able to access support without guilt about feeling that they are taking up hours that could go towards a primary victim.
- We do a whole of family assessment if the trauma is impacting on family relationships / the family system and we act where the family feels they need assistance
  - Some of the identified risk issues concerning children of survivors include: young people being at-risk due to their behaviours/wellbeing issues, children being at-risk due to their behaviours or wellbeing issues, Child Protection involvement/Protective Orders, Post-separation experienced by children, teenage/young pregnancy
- Family members were the first to hear a disclosure for a number of service users, and friends for some
- In the effort to ensure that there are no conflict of interest issues when offering services to secondary victims where we are already working with a primary victim with whom the secondary victim has a relationship, we allocate to another practitioner than the one the primary victim sees.



## 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?

- Practitioners who have the primary role to work with RC clients have all been trained in queer affirmative practice and undergone training around cultural sensitive practice with those impacted by violence. (as drummond street services workers have)

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?

- Programs need to empower clients to have agency in their lives, and equip them with the knowledge and support necessary to engage with social and legal infrastructure.<sup>1</sup>
- Drummond street has experienced high numbers of LGBTIQ clients accessing our RCSS (at least 8% neither male nor female; transgender status with 29% unknown; and at least 17% non-heterosexual, ~30% 'unknown'). Therefore there is a need for specialist knowledge/skills regarding the interface between sexual (and other forms of) abuse and sexual identity and orientation.

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

- Ensure embedded program workers within correctional institutions have undergone training around the issues for those who have experienced child sexual abuse within an institutional setting. These workers can then do the assertive pathway referrals, i.e., linking prisoners upon release.

## 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)?

- Some RC clients are minimally computer literate so to access web based technologies is difficult. Even for those that have skills in ICT use, the financial barriers faced could get in the way of paying for an internet connection.
- Outreach services are stretched and we need to consider how services are offered in the clients natural setting, i.e., clients home or where a client can access a service that is within reasonable and affordable travelling distance
- In a sample of clients drawn from the first 18 months of our RCSS we found that 3% attend from wider Melbourne Metro, 15% from Victorian rural town, while 6% participate from Queensland, and 3% from Geelong Metro. 3% unknown.
- The demands on the provision of outreach services to RC clients has to date been manageable. However, should we experience a significant increase specifically for

- outreach, including on-going support, it is reasonable to foresee that will put pressure on our capacities to offer outreach RCSS. This is primarily related to no time or session limits for RC clients. An approach that ensures that any agency funded to deliver services to survivors commit to outreach models of will reduce this pressure and enable agencies to maximise the availability of resources for direct service delivery. To date outreached and in-home support has been approximately 30% of clients. The impact of outreach with respect to service deliver time is indicated in the following:

Outreach visits	Return Travel Time	% of clients
	1.5 hours	7%
	2 hours	5%
	3 hours	18%

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

- Flexibility and choice of service is important, with 15% accessing our inner Melbourne-based service from rural areas, and 6% interstate via alternative methods such as skype, teleconferencing etc.
- There is a group of clients whose intermittent use of the service is determined by their own assessment of their mental state or their knowledge of the trajectory of their psychological states. Clients contact when they need support, which is often in the form of an immediate phone dialogue to support management of specific trauma symptoms or potentially triggering experiences. Mobile phone text messaging systems that enable clients to give near real-time communication about their state, coupled with call back systems, may be useful for those clients who benefit from immediate contact at times of escalation.

## 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?

- By virtue of providing separate working definitions for each of ‘advocacy and support’ and ‘therapeutic treatment’, one might get the impression that these are distinct services delivered in isolation from each other. Drummond street approaches these service modalities as interconnected and co-deliverable in the context of a dynamic spectrum of interventions. Client needs and circumstances require that service responses are capable of moving between advocacy and therapeutic intervention, since the advocacy process is often a triggering experience for clients who have a history of child sexual abuse and resulting trauma. Drummond street understands the necessity to provide discrete working definitions but does not support this need translating into discrete services

- The following is a comment on the working definition of therapeutic treatment:
  - As part of the working definition, the Issues Paper states that “Therapeutic treatment aims to reduce symptoms of ill-health and bring about measurable change in outcomes that improve wellbeing and quality of life.”
  - With its emphasis on the aim of reducing symptoms of ill-health, it’s possible to read the definition of therapeutic treatment as 1) overly focused on the presence of illness and 2) overly narrow. Regarding 1): the World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>2</sup> Grasping notions of health and ill-health through the lens of a public health framework that articulates the social determinants of health in a range of domains, Drummond street locates therapeutic intervention in the context of assessment of a range of risk and protective factors for individual and family and community wellbeing. We believe that this provides a sound foundation for consideration of the full range of needs and potential interventions that are most likely to promote wellbeing and quality of life for all impacted by childhood sexual abuse in the institutional setting. Regarding 2): The definition could be read as being focused on symptoms of ill-health that attend to individuals, which is also not consistent with the WHO focus on the ecological foundations of health.

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?

- There is a need for the supplementation of existing specialist services (not RCCS) to enable responsive and intensive services as required, while also see the need for a built capacity to support survivors within our broader service system; mental health, AOD, homelessness and family services, as well as primary (physical) health services that are trauma-informed.
- Some adults who experienced childhood sexual and other forms of abuse within institutions have supportive families to protect and support their recovery, while others have no such support available, and others experienced direct abuse within their own families. Family protective factors no doubt influence impacts and recovery trajectories, hence, it’s important that existing and new services adopt family-aware practice and even family-inclusive practice within this work.

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?

- Produce materials that described the evidence base regarding adult recovery from childhood trauma, and include this material in in-depth practice guides for a number of sectors, including Mental Health, Alcohol and Other Drugs, Family Violence, Family services.

- Education for practitioners and survivors regarding the long-term physical impacts of abuse/trauma, for example due to chronic stress to assist with assessment and understanding of needs that are linked to a trauma history

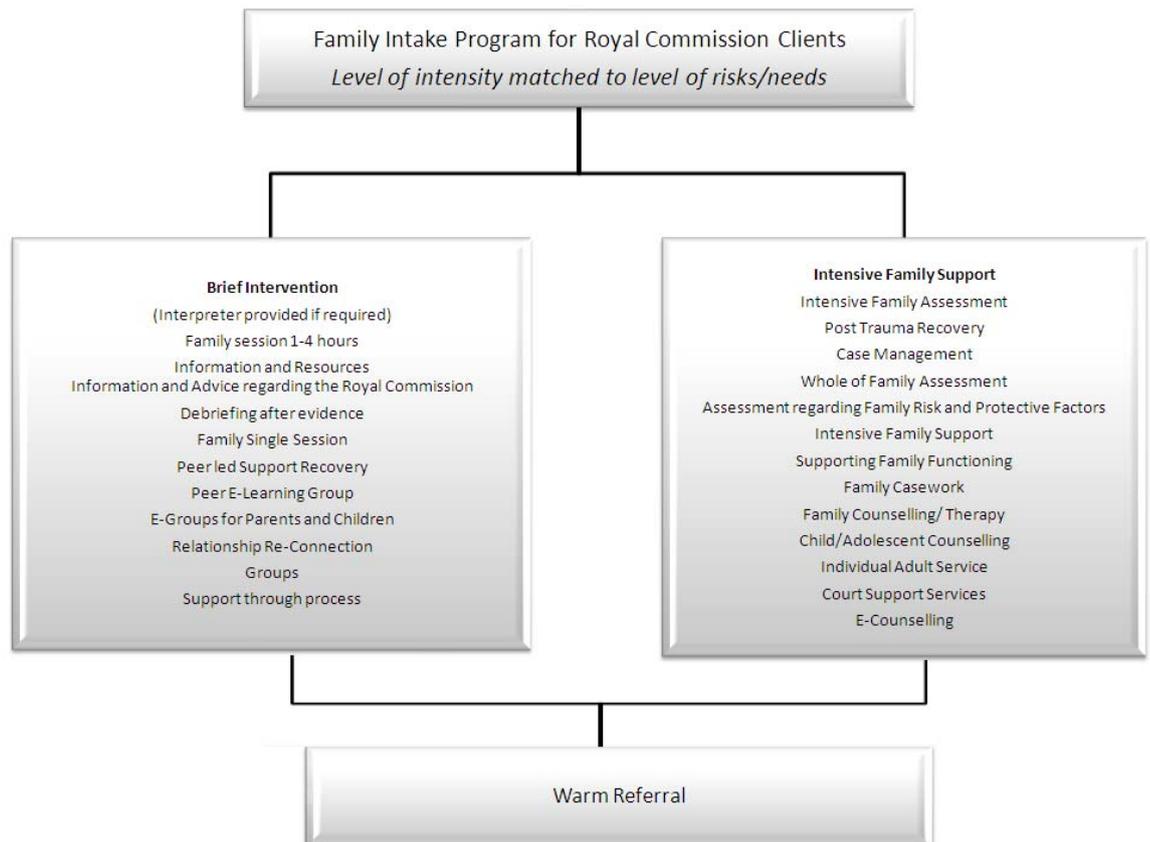
## Topic E: Evidence and promising practices

1. What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional child sexual abuse are emerging from practice-based evidence? Where are these available and who can access them?
  - drummond street has developed a community-based, evidence based individual and whole-family support model of care, underpinned by our existing trauma informed care framework, embedded across all of the agency programs and approaches – recognising the nexus between poor mental health, substance abuse, family violence, suicide ideation, relationship formation and histories of child sexual abuse and the long-term impacts on victims and their families including risks of transmission of intergenerational sexual abuse.
  - drummond street’s support model incorporates three key activities matched to the timing and intensity of support required/requested and level of complexity and impacts for both survivors and their family/significant others.
  - It is important to offer support that is flexible, responsive and directed by each individual at the time in which they need; both survivors directly affected by institutional child sexual abuse (CSA), their families and children and those indirectly impacted (vicarious trauma).
  - Drummond street support through a skilled, multi-disciplinary team of clinicians, support/case managers, one-to-one support and peer-led groups through face-to-face support, telephone and e-counselling and groups. dss offers services across a significant catchment of Melbourne, with additional capacity to offer this support state-wide through:
    1. Royal Commission Engagement Support Services (enables survivors and their families informed decision-making, awareness, understanding and planning for the process).
    2. Brief Support for CSA survivor’s and their families (up to 6-10 counselling/practical support sessions dependent on needs), prior, throughout and post-Commission debriefing to assist with stress/distress as a result of increased attention of CSA within the community (indirect impacts); and to address specific issues for survivors (and whole-of-family e.g. supporting survivors/victims to discuss/engage with family members/peers etc., to reflect/understand impacts, achieve and maintain healing and recovery).
    3. Intensive whole-of-Family Support for complex, accumulative and long-lived trauma requiring case work/management, supportive counselling, self-

directed recovery across multiple health/wellbeing impacts (Bio/psycho/social). Supporting survivor's family relationships and functioning for survivors and/or family.

- drummond street (has employed a core team of practitioners who respond to the bulk of RC requests for service
- Acknowledging that rates of referral and demand has varied, and that working with complex trauma over time can have an impact on practitioner wellbeing, drummond street's core RCSS team is complimented by a wider team of qualified and experienced practitioners all of whom have been trained and provide support in accordance with the ds service model . All drummond street's programs and services have embedded a trauma informed and whole of family approach which recognizes the links between mental illness and mental health problems, health and wellbeing risks such as problematic alcohol and other drug use, family violence with history of child sexual abuse. In addition it further recognizes the long-term impacts on victims (into their adult lives) and their families (including children).
- We have a skilled, professional and multidisciplinary team including; clinical, general and health psychologists; social workers; youth workers; and parenting educators who aim to deliver services that are responsive, innovative, recovery oriented, trauma informed Family work.
- drummond street has a well-established centralised intake screening and assessment program which enables identification of both risk factors and protective strengths for all family members. ds provides a full suite of services in line with Mrazek and Haggerty's (1994) 'Mental health Intervention Spectrum' which recognises that to address health risk issues, efforts need to be made across the entire spectrum of intervention. Where risks are assessed to be not as significant, families are provided with brief support in the form of information, referral, short term counselling or case work (up to six sessions) psycho educational group programs and peer programs. Our Intake and triage practitioners ensure co-directed family interventions, which wraps programs around families rather than fitting families to programs. In cases where there multiple and complex risk factors are present a Whole of Family assessment is commenced within one week of initial contact. This is also foundational of our approach in our RC work.
- This approach allows ds the flexibility to ensure that we are always thoughtfully deploying our resources to meet the particular needs of each client.

- The model below outlines the types of interventions that we offer to RC clients. All clients are supported and case managed throughout the process; wrapping services around clients, skilled practitioners are also able to work with other organisations, where required, to achieve the best outcomes.



## 2. What evaluations have been conducted on promising and innovative practices? What have the evaluations found?

- The RCSS Program Review examined data relating to any service users/clients who had contact with ds during the initial 18 months of the RCSS service delivery at ds (July 2013- December 2014). Data examined included:
  - brief/limited data sets available for RCSS clients who were not registered on our ds Client Information System (CIS) data;
  - data available on CIS
  - ds Client Feedback data; and

- data compiled for this review purpose by RCSS practitioners/ds researcher via a Client Audit Tool (re the cases which proceeded to receive a service beyond intake).

The outcomes of this review are reported on throughout this document

3. What other learnings are emerging from practice-based evidence or from grey literature (i.e. published reports and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?

- The answers to many of previous questions reflects drummond street's learnings from delivery of our RCSS over the past 2 years.