

# Issues Paper 10 Released 1 October 2015

## Advocacy and Support and Therapeutic Treatment Services

Response – dated: 12 November 2015 - prepared by:  
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### Topic A: Victim and survivor needs and unmet needs

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

Preamble: The circumstances of survivors are all different. What works for one will not work for another. Any services based on the five principles of the Trauma-Informed Practice as per ASCA guidelines (Adult Surviving Child Abuse (asca.org.au)) being **safe, trust, choice, collaboration, and empowerment** will go a long way in supporting the survivor to recover from complex trauma.

- a. Opportunities provided to the survivors to break the isolation and normalise their feelings and their behaviours help. They may be non-invasive electronic options such as online newsletters or printed magazines (eg ASCA, DPI Rural Support Program), or webinars (eg. Mental Health Professional Network (mhpn.org.au) webinars which all can attend inclusive of survivors), or face-to-face options such as support groups with a focused survivor facilitator, clear rules and purpose. (See as an example: [http://www.itmatters.com.au/childAbuse\\_support\\_Cowra.html](http://www.itmatters.com.au/childAbuse_support_Cowra.html)).

Such support groups have been criticised as a potential avenue for re-traumatising. Support groups do fill that gap where people learn new behaviours, make mistakes and seek from survivors in the community how to get over their daily hurdles. The risk of not having a support group is greater than the risk of having a support group which may re-trigger a survivor. Survivors get re-triggered by professionals all too often anyway so the argument of risk does not stand. **Empower** survivors by facilitating options and let them choose whether this **option** is a viable option for them. The above-described opportunities do not require a great budget either.

- b. The Centre for Rural Research and Mental Health (CRRMH) provides workers who can liaise / advocate between the survivor/friends/carers and the medical team. This is helpful to establish the missing dialogue with the treatment team.
- c. The currently offered ASCA (asca.org.au) training on Trauma-Informed practice is of quality to practitioners and survivors.
- d. Access to affordable trauma-informed trained practitioners with experience focusing on what the survivor needs to achieve to lead a better daily life works.

## 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?

### a. Lack of safety:

- i. Scheduling a survivor presenting with high distress in the lock-up ward of a psychiatric hospital where other patients bang the walls and shout for help are not evidence of a safe and therapeutic environment.
- ii. Allowing visitors in a lock-up environment who are well known to staff for being re-traumatising to the survivor is not protective of the survivor. Expecting the survivor to stand-up for themselves in times of crisis without support is not realistic. When 'No' is too hard to handle, one can start with 'Not today' or a written list of agreed visitors reviewed at times.
- iii. The building / room: at surgeries, at psychologists, at institutions such as psychiatric hospitals - addressing claustrophobia, allow for exits, bright spaces, access to outdoors.

b. **DISempowering:** Treating a survivor with Electroconvulsive therapy (ECT) when it is soon realised that the survivor loses short term memory because of it breaks both the principles of safety and trust. Indeed the survivor can no longer rely on their own short term memory, does not remember conversations on treatment plans, on the way carers may feel towards them, on the situation at home etc. It DISempowers them therefore re-traumatising the survivor.

### c. Communication

- i. **Abuse of authority:** commonly witnessed in the health sectors. Mental health nurses and practitioners need to be well aware of their position of authority and not abuse of it. Survivors often either rebel to or melt in front of authority figures.
- ii. **Demand an improved command of the English language:** The professionals involved – especially in high distress situations such as lock-up ward – must be able to easily relate with the survivors – a minimum requirement is a strong command of the English language with little foreign accent. Unfortunately both 1800 call centre and medical staff even at psychiatrist level present with the inability to use the English language in a clear manner. This is highly distressing for a survivor or carer of an English background. Catering for all languages is not a realistic option given the already scarce resources.
- iii. **Lack of understanding of treatment plans / options:** Trying to understand who the stakeholders are and how the care / discharge plan works is really difficult and certainly not openly documented.

d. **Professional training**

- i. **Compulsory complex trauma certified training for mental health public health staff:** The training budget at the moment is all consumed by alignment to laws: OH&S, First Aid, etc - but has little relevance to the patient. Learn enough to identify complex trauma clients, and relay the information gathered on a daily basis to the psychiatrists/psychologists.
- ii. **Training in complex trauma:** and able to address the high emotions and reduce them without these extreme DISempowering treatments – EMDR may be such approach.
- iii. **Adequate qualifications and experience:** Many sexual assault workers and community health staff have limited qualification. It is commonly spoken amongst survivors that professionals have not dealt with their own personal issues and are in the business of fixing rather than enabling, often trying to fix themselves rather than providing insight and options to survivors.

e. **Patient-centric approach:**

- i. What survivors need is a **therapeutic approach**. Use the time in lock-up to acknowledge their feelings, not belittle them. At the moment this time spent in lock-up is not spent in empowering survivors. Mental Health nurses could be trained to be therapeutic instead of what appears to be a role of jail warden. They could become facilitators of a support group started within the institution.
  - ii. **Power and secrecy** (in regards to treatment and plan) appear to be the main driver, not the well-being of the patient.
  - iii. **Follow-up and support during recovery:** The program under: <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors-phams> provides support for people with severe illness. Survivors probably do not fit this bill. But a similar service could be explored for survivors.
  - iv. **Empower** social agencies which claim they have no resources, and fear to enter survivors' home and offer a hand, an ear, real support. This fear is physical as well as driven by a fear to lose their job by not following work protocols driven by laws which are not patient-centric.
- f. Information days on Domestic Violence, Suicide etc using government grants do not seem as effective as on the ground troops initiatives such as health checks/discussions at Field Days or visits by community members (such as patrolling ministers, DPI rural support officers).

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?**
- a. **Geographic isolation:** Development of online support groups or mailing lists, more webinars, support for telephone conferences for support network of friends / carers and survivors to catch up and share their joys or concerns help break the isolation.
  - b. **Finance:** Survivors need access to **affordable** trauma trained practitioners. A lack of finance in rural areas translate in access limited to poorly trained staff.
  - c. **Job security** in the public service especially in rural areas is a problem when vicarious trauma occurs and professionals do not recognise it and continuously re-traumatise their clients. Are there useful measurements of outcomes in place or feedback mechanisms to assess the ability of the practitioner? Should public health practitioners be like the army and be rotated after a number of years in a community where job security takes over patient care?
  - d. **Education:** Whilst survivors engage on their road to recovery, their carers need to **understand** what the treatment is and why, what their role is, what the effect on ECT (if applicable) may have on daily events – such as the need to repeat conversations, apply more patience. So they need to be **educated**.
  - e. **Communication:** A **dialogue** needs to be started between the medical team, the survivor, the carers, and network of friends. This dialogue would have an exponential positive effect as the community members involved would feel empowered and better armed to explain it to others, to care for their friends, and start a real breaking down of the mental health stigma within the wider community.
  - f. **Early diagnosis:** ASCA ([asca.org.au](http://asca.org.au)) provides certified professional development based on these guidelines. If government services and Primary Practitioners (such as General Practitioners) were **trained in Complex Trauma as a compulsory item to be entitled to be part of the Australia Health System**, it would help towards earlier diagnosis and better care of survivors in the practice. Ideally early diagnosis would also avoid greater cumulative effects and crisis times which clearly have no adequate resources at the moment.
  - g. **Empower mental health staff:** By providing focused complex trauma training and extending the role of the nurses, say, to facilitating support groups makes their work more satisfying, their relationship to the survivors more genuine. The outcome is better for the survivor, for the well-being of staff, and for the system as the staff turn-over may be reduced.

- h. **Review Key Performance Indicators:** for public health staff and services subsidised by government. Design patient-centric outcomes rather than mathematical formulas so that staff change the focus from patient-centric rather than filling in forms and providing statistics.
- i. **More ‘action teams on the ground’.** Most carers do not see any workers in their environment / home. The resources on the ground are extremely scarce, especially in rural areas so the situation is akin to teaching the survivor new swimming skills in a calm pool, then upon discharge, throwing them in the deep end with no one on the side encouraging their progress. No parent would act in such way for their kids swimming lessons and learnings, how can we expect that from survivors and their families?
- j. **Empower communities:** Diminish the need for crisis responses by empowering the community - the Australian people are overgoverned and people feel crushed by the law. Community spirit is dying. Only community support can help the survivor bounce back in rural communities where anonymity is hard to keep and judgments hard to stand. The wider community feels powerless at the moment when situations escalate from undiagnosed complex trauma to extreme crisis. **Encourage the development of a support network** – eg a team of 7 friends on a weekly roster. Some of the support mechanisms do not have to be costly. What they require is **education** of the support network on complex trauma and their role in recovery, and an understanding of how to access professionals if needed.

#### **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?**

- a. Empowering communities, providing education, and more on the ground resources – all above mentioned – would help shape better services.

#### **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?
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?
  - a. The Issues paper includes under the heading of diverse victims: Aboriginal and Torres Strait Islanders (ATIS).  
During Mental Health week an initiative by the ATIS group of having elders at the psychiatric hospital in Orange for ATIS patients came to my attention. After having spent a few days visiting non ATIS patients at the same institution I applaud the above initiative which would certainly play a part in enabling survivors to connect with other trustworthy humans, and start therapy in a

meaningful way. But this is not available to non ATIS patients ...

The approach of marginalisation is not appropriate in my view; it fragments the effort, the expense, and creates amongst community members a bitter taste of segregation, feeling left out. I trust we can devise a system for all with flexibility so we can adjust our approach depending on the person's needs. Identifying yourself as ATIS does not mean that all ATIS remedies will work for you. As a matter of fact my late husband and survivor never wanted to be identified as ATIS as he wanted to feel part of the overall Australian community. As a migrant from a non-English speaking country, and survivor myself I know the usage of labelling and categorising can be useful but is mostly restrictive as people feel they have to respond in a certain way. We are all different regardless of belonging to a race or religion yet survivors present with great similarities in feelings and behavioural patterns or yearnings which a common approach can mostly address.

Genuine human connections and rapport go beyond all differences. Love is core to the pain of survivors. Trust is a major issue. These are only two examples of the similarities of the diversities of survivors. Approaching the recovery by fragmentation in an already weak and poorly resourced system will only aggravate the situation. A broken heart is a broken heart no matter what race, sexuality, religion, gender. This is greatly simplified but hopefully will help focus the energy on the core issues and unite the services and effort rather than divide.

3. What would better help victims and survivors in correctional institutions and upon release?
  - a. Above comments on discharge plan from mental health institutions would have great similarities with correctional institutions; they both suffer great stigma and probably the same lack of follow-up and adequate support to the survivor and the family. The main important difference is the likely lack of any acknowledgement and treatment of the survivor in the correctional institution.

### 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)?
  - a. **Scarcity** of appropriately trained service providers
  - b. **Distance** to providers, friends and support network and its incompatibility with caring for a family
  - c. **Financial cost** to access the service
  - d. **Mental health stigma** puts pressure on the survivors as survivors often do not look sick – the pain is within – and the rural community and husbands may well – often unintentionally – pressure their non-assertive wives to get over it. (Similarly applies to men survivors expected to ‘act as a man’ and ‘get on with the job’)

2. What would help victims and survivors outside metropolitan areas? Are there innovative ways to address the geographical barriers to providing and receiving support?
  - a. A range of delivery options: electronic, mailing, face-to-face, telephone conferences, week-end workshops
  - b. **Educate the rural areas using examples they can relate to:** The CD *Mate Helping Mate* featuring John Harper (NSW DPI and CRRMH resource) uses the example of the animal away from the herd which indicates a sick animal and how a farmer would cater for it. Build resources and analogies of the kind to educate – use cartoon strips – short and to the point and have these included in all the fairfax newspapers in the rural areas in the same manner as Footrot Flats has the glory at the moment. Introduce a character which you can develop nationally in your national cursus in schools to educate the kids too.

#### 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?
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?

Response: Keep it simple. The core issues are not so varied really. One can spend time and resource in planning all details or provide for the main priorities and re-assess and tune the system as it evolves.

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?

Response:

Compulsory complex trauma training for General Practitioners and Nurse practitioners as they usually see the survivors and the earlier the diagnosis the better.

The relationship between a survivor and a practitioner is unique and very personal. There is no black and white approach either. Educating the survivor in what feels right and what does not and reviewing the progress with a third party such as the General Practitioner against some clear goals is a rational way to approach some feedback mechanism. This is akin to asking the question ‘How can we ensure there is no paedophile in the community?’ We can’t. What we can do is empower our children and have clear communication channels with our children so they know what feels right and what does not feel right and they know who to talk to when something happens. Empower rather

than rule and the community will grow into a more independent and confident society.  
(Refer to the book *The Silent Crisis*. By Amanda Robinson)

### **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?

There are SO many resources available and often ignored eg SMART (Strategise for Managing Abuse Related Trauma) in schools and developed by the SA government and Monash university (see childhood foundation website).

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