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### ***Issue Paper 10 – Advocacy and Support and Therapeutic Treatment Services***

#### **About the agency**

Anglicare WA is an incorporated not-for-profit organisation delivering a range of services to communities in 62 locations across Western Australia. Anglicare WA works together with people, their families and their communities to enhance their abilities to cope with the challenges of life and relationships. Anglicare WA's Vision is that "we live in a just and fair society in which all people thrive". As a leading not-for-profit organisation, Anglicare WA has an important role in building strong communities and families, supporting people to enhance their resilience and capacity to thrive. The work of the organisation is focused on delivering services that assist the most vulnerable people to participate fully in community life, by helping them to overcome relationship, housing and financial difficulties, and to access community support.

Anglicare WA services are underpinned by a principle of strong corporate governance that protects and enhances the interests of all stakeholders, staff, clients and the wider community. The core values of Compassion, Responsiveness, Inclusion, Empowerment and Leadership are embedded in all of the organisation's activities and decision-making, and all work is undertaken in a spirit of reconciliation between Aboriginal and non-Aboriginal Western Australians.

Anglicare WA's responses to the questions should be read in the context of a range of broader issues shaping these practices, discussed in the attached appendix.

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

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

The ideal and overall principle is that the least number of professionals directly involved with a victim/survivor at the time of the abuse or its disclosure, the better. Unfortunately, in many circumstances there are multiple agencies represented and involved from the point of disclosure. In WA this can include the person to whom the

initial disclosure was made, childFIRST staff who assess all new referrals of child sexual abuse in Western Australia and other Police, and child protection workers.

Beyond this, recent victims need immediate responses, coordinating both treatment and ongoing support through a minimum number of people and systems. Best practice might be that one appropriately skilled therapist (of whatever discipline) coordinates with one case manager to ensure that both psychological and other supports are provided as soon as possible. Depending on the nature of the offences, the age of the child and their available family support, case management might need to then liaise with a number of other workers and to be in place for weeks, months or longer if court processes are happening. Likewise the length of time psychological support is required will vary and may also need to be intermittent depending on the requirements of specific children.

For survivors from previous abuse who make disclosures now, it may be that the best approach is for the therapist to also be able to provide a level of case management/advocacy, assuming that the survivor may have greater capacity to manage resources and referrals themselves. If this is not the case then a similar model as above should apply: the therapist and a case manager coordinate with any other required services.

Therapeutic treatment models need to have some level of recognition and validity and some have known to have greater efficacy than others but, as is commented on below, the model is only part of the equation of assistance. The experience, skill, interest and empathy of the worker are another (and imperative) factor. A third factor is the familial and social support system in which assistance takes place.

***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?***

As above, possibly one of the most damaging things for victims and survivors is having too many professionals, services and agencies involved once an allegation of abuse or longer term disclosure is made. Unfortunately victims and survivors often don't receive stability, consistency and ongoing support over a long period of time, which is most needed. Recounting the abuse multiple times to strangers, frequent changes of counsellor or case manager, confidentiality and privacy becoming an issue and poorly established support or support which encourages dependency can effectively re-traumatise or re-abuse a victim and do nothing to assist a victim to move toward recovery. The offer of only time-limited counselling is often of no benefit to long term survivors.

The next most distressing factor is that poorly skilled counsellors frequently fail to tell victims or survivors that recovery is possible through recognised pathways, that the abuser is responsible for the abuse and that the abuse was not in any way the fault of the victim. These apparently simple statements can make the world of difference to victims.

Poorly skilled workers can avoid direct discussion of the trauma, or alternatively, can continue to endlessly discuss traumatic details without moving forward to a recovery

stage. In the book *Trauma Practice – Tools for Stabilization and Recovery*<sup>1</sup>, Eric Gentry has noted that:

..... early in his career as a trauma therapist he spent many therapy hours working with clients to establishing safety and stability. However, on closer inspection he saw that this delay was his own anxiety about approaching the traumatic material that actually escalated the crises of (his) clients. The safety issue was as much about his own emotional safety as that of his clients....

The authors go on to say:

A protracted period of attempting to over-develop safety for these clients is not helpful – what is needed is an approach which develops the minimum (“good enough”) level of safety and stabilization and then addresses and resolves the intrusive symptoms by enabling a narrative of the traumatic experience. This is often counter intuitive and almost always initially anxiety-producing for the clinician. However the client will be much better equipped to change his/her self-destructive patters (e.g. addictions, eating disorders, and abusive relationships) with the intrusive symptoms resolved because s/he will have much more of their faculties available for intervention on their own behalf. (p18)

In addition, some workers may not understand the benefits of formal diagnosis that is helpful for some victims and survivors. Comorbidity may also not be understood. For instance a client may be diagnosed with posttraumatic stress disorder and a substance use disorder and general anxiety. Each of these requires different treatments at different times. Although theories vary about which to address first, it is hard to provide therapy if the victim or survivor is currently using alcohol or other drugs. As noted in the quote above, poorly skilled therapists may not be aware of fairly simple approaches that they can teach to victims to prevent trauma symptoms overwhelming them.

A very recent article has looked at the commonalities in different types of therapies and has found that:

the identified commonalities (psycho-education; emotion regulation and coping skills; imaginal exposure; cognitive processing, restructuring, and/or meaning making; emotions; and memory processes), point to future directions such as trying to better understand the underlying mechanisms of action, and developing treatments that are tailored to the needs of different patient groups.<sup>2</sup>

Advocacy and case management should be conducted in such a way that wherever possible, clients learn how to find and make contact with resources for themselves and therefore to gain independence and the right to self-determination.

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<sup>1</sup>, Baranowsky, Anna B, J Eric Gentry, Franklin J Schulz *Trauma Practice – Tools for Stabilization and Recovery* Hogrefe and Huber 2005

<sup>2</sup> Ulrich Schnyder · Anke Ehlers · Thomas Elbert · Edna B Foa · Berthold P R Gersons · Patricia A Resick · Francine Shapiro · Marylène Cloitre *Psychotherapies for PTSD: what do they have in common?* in *European Journal of Psychotraumatology* 6:28186 · January 2015

It is also at this point that support and input into the wider family and community can do as much to help the victim as can some forms of work with the victim.

One other addition can be very helpful and that is for administrative workers to be fully trained in trauma-informed practices. This group can include everyone from the reception staff at not-for-profit services to Centrelink staff, to police and state government workers. If all clients are treated with respect and their information managed sensitively, victims of child sexual abuse will also benefit.

Often the perpetrators (when not convicted) return to reside at the same remote community as the victim. The perpetrator is often a family member and this sends a message to the community that the offence did not occur. Some victims receive safe and appropriate responses from family and community, unfortunately some victims are re victimised by taunts and growling's and are displaced within their family kin and community.

This support required is a whole of family and community response. Where the immediate family is safe and supportive this can be achieved; whilst maintaining the confidentiality of the young victim. This proves difficult when extended family and community are unsupportive and in denial; particularly in maintaining the long term emotional and physical safety of the child.

It should not be assumed that in every remote/rural community there is a safe and protective elder/community member and/or group that could provide support in the absence of therapeutic services. Many who step up in community and take an active role are often overburdened by multiple requests from agencies, are related to both the victim and perpetrator and overwhelmed with their own trauma and responsibilities.

***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?***

Well known, well-advertised services in the form of multi-function centres can provide a good model for initial treatment, because these are generally large enough to offer both specialist therapies in a wide range of fields and general advocacy and case management. A "no wrong door" approach is essential. At the same time such services are more able to offer their staff good training, support, mentoring and career paths.

Perhaps a major barrier to receiving support and or treatment will be reduced by the Royal Commission – many people have not come forward in the past as they didn't believe they would be believed. Now the most common barriers might be the short term nature of counselling, lack of perceived skill in those assisting, financial costs to the client – both direct in terms of fees and indirect in terms of child care or travel, lack of services to refer to for other matters and many others, some of which will be commented on below.

At a psychological level, the symptoms of trauma often cause people to avoid or reject the very assistance and support they desperately need. Lack of trust might keep people from telling their story, avoidance and numbing about the traumatic events reduces help-seeking, hyperarousal or attention difficulties can limit learning of skills, risk taking can be limited and isolation often feels safer than engaging in treatment.

At a practical level, in remote and regional communities what often makes the difference is the presence of Police in the community and their capacity to win the trust of women and children. For example, when a major child sexual abuse crisis irrupted in the remote community of Halls Creek WA in 2007, the local member of Parliament, Carol Martin was quoted as saying:

I would argue that when you're fighting for survival and, you know, living every day worrying about whether you're going to get beaten, it's pretty hard to work out, you know, the long-term future when you're just trying to survive for the day. The police presence has enabled women to make those decisions. It means that people can actually get on with the business of their families instead of having to put up with the lawlessness that's been happening.<sup>3</sup>

Returning to therapeutic processes, a major issue for many older people now may be overcoming the previous poor, invasive, demanding or dehumanising treatment they have received. Many have had their trauma symptoms misdiagnosed and "medicalised" and in the process have decided against opening up to another person again. This is a major hurdle to both disclosure and recovery.

As commented on earlier, victims and survivors are often reliant on their family's understanding to ensure they are supported in attending treatment or support. Unless families are engaged well, the magnitude of the hurt and potential damage from not seeking help may not be clear.

Regular and robust funding for consistent outreach is required to provide therapeutic treatment to victims of sexual abuse and assault in remote and regional areas. Some services are funded to only provide monthly outreach, whilst this may be adequate for secondary victims/adults it does not allow for strengthening the therapeutic alliance with children.

A coordinated response is required from child protection, therapeutic services and in some cases, elders and other stake holders in remote communities to provide the basics. This includes, a safe and private setting to provide therapeutic services, support/facilitation in spreading the strong message that victims will be believed and supported and this behaviour is unacceptable and illegal.

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<sup>3</sup> Report on the news program AM on July 10 2007 the ABC at <http://www.abc.net.au/am/content/2007/s1974333.htm>

**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?***

Our commentary on the first question is limited except to say that we understand that a great deal of State and Commonwealth funding explicitly does not count work with secondary victims as eligible for funding or as statistics. This has the effect of undervaluing the time spent with secondary victims and of underestimating the true cost and time involved with primary victims. It also gives a clear message both to the primary and secondary victims about how they are valued.

Regarding the second question, services for secondary victims often need to be conducted outside of office hours, possibly offering more group psycho-education, group discussion and planned joint sessions between victims and their families. Once again, this is a highly skilled process often using more than one therapist, which needs adequate funding as it is costly in staffing, time and financial terms.

As has been mentioned above and elsewhere in this paper, therapeutic effort put into secondary victims reaps benefits for them, for their victimised family member and for the wider community. We think it is also likely that some secondary victims have been primary victims themselves at some point and therapeutic treatment then has the effect of assisting several generations.

Provision of psycho-education to the general public regarding the impact of secondary trauma is necessary. Many secondary victims do not identify as such, they hold the belief that as it did not happen to them they are not entitled to access support and must remain strong for the primary victim.

**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?***

Centres should be culturally accepting for a range of people and staff representative of the attending population, if at all possible. As above, professional staff must be qualified and experienced as well as culturally safe. Many therapists would argue against development of further models for specific populations – arguing that trauma treatment skills are the same for all such groups but the critical skill is applying such knowledge to the population in question.

**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?***

Involvement of safe and protective elders/community members, with the consent of the victims and families, to provide support in either a practical, educational or emotional level e.g. organise community meetings and facilitate delivery of

therapeutic services. This involvement could send a clear message to victims and families that they are believed, that it is okay and helpful to tell their story and sends a message to the wider community that this behaviour is not acceptable.

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

There is much to be said for both independent visiting counsellors and internally employed counsellors in prisons and juvenile services. The former may be seen to offer a better perception of independence and privacy but the latter have a better understanding of the pressures on prisoners and the milieu in which they live.

It is important to note that the Royal Commission has not yet adequately investigated abuse which has occurred in juvenile correctional facilities and the previous child sexual abuse that has occurred to a proportion of all adult offenders and which may be directly linked to their psychological dislocation and starting upon a criminogenic pathway.

There is increasing literature to suggest that there is a connection between traumatic experiences and criminal behaviour,<sup>4</sup> but it is also important to understand that working with imprisoned survivors requires a lot of forensic knowledge about offenders and their thinking, not just a knowledge of victim based trauma. There is also some trauma literature to suggest that trauma symptoms can enhance criminal capacity: that is to say, dissociation, hyperarousal and avoidance and numbing may give some people more ability to offend.

A critical first step for any treatment in correctional facilities would be a professional intake assessment that canvassed childhood trauma, other trauma, current mental health, AOD issues and other criminogenic factors. This is not yet a universal practice in Australia. Once again, the sooner such assessment is made in a sentence, the faster treatment should be offered.

However, it should be noted that many people who arrive in prisons may only be there as long as they can't get bail and/or are not yet sentenced, even if they can't get bail. The implications of these facts are critical – for example, those who can be bailed may not want to discuss matters when they might leave at any moment and both groups may not be able to discuss matters that may lead to self-incrimination prior to a trial. Early assessments may then be slowed down by legal matters which limit therapeutic services to offenders.

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<sup>4</sup> See for example, [Vittoria Ardino](#) *Offending behaviour: the role of trauma and PTSD* in *European Journal of Psychotraumatology* 2012; 3: 10.3402/ejpt.v3i0.18968. Published online 2012 Jul 20. doi: [10.3402/ejpt.v3i0.18968](#) PMID: PMC3402156

## 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)?*

Anglicare WA has staff members in regional areas including the East and West Kimberley regions, Albany and closer to metropolitan Perth in Mandurah and Bunbury.

They have raised the following points regarding *services and staff*:

- Regional services generally receive considerably less funding than metropolitan areas and the shortfall often results in part time positions being offered.
- Regional services have to pay considerable extra costs to maintain their services.
- Extra costs include,
  - petrol and transport costs for day to day work
  - the time workers spend travelling to see clients
  - Additional travel costs to attend education and training opportunities
  - Office rental, electricity and phone costs
  - Accommodation costs and access in remote locations
  - Access to remote communities during inclement weather
- Attracting and keeping sufficiently qualified people to the regions is an ongoing challenge and (costly) incentives and logistic support need to be considered more.
- In communities where regional universities are situated, local people are more able to be upskilled and encouraged to remain in the region.
- Career paths are often lacking in regional areas as are amenities and opportunities to diversify.

Another group of issues refers to the *legal systems* and very small communities of 20-300 residents:

- Law enforcement must be available in some communities before clients will make disclosures.
- As above, sometimes the alleged offender is a community leader, or the one who gets bush food for the community, or is integral to other community obligations. This may mean that disclosures are limited or that those who disclose may be forced out of the community before the offender is.
- There is often a poor understanding of the legal system by policy makers which can have massive effects in small communities. For example,
  - charges against an alleged offender may take 12-24 months to go through the courts and in the meantime such offenders may remain in their community
  - in some small communities, registered sex offenders may live in the same house, in the next house and down the road from children

- o many workers in those communities may not know such vital information about the offending history of locals
- o offenders, having spent time in jail, may return to a community, remarry and have access to their own children, if not others in the community.
- o peer on peer abuse has been generally under-recognised in communities, treatment options are very limited and so are community justice services.

Another set of issues relates to the *dissemination of knowledge* in remote and regional communities. For instance,

- the turnover of staff means that local knowledge is constantly being reinvented
- local and 'imported' staff can easily be drawn into or excluded from networks which maintain information and knowledge for the purposes of power and control.

Finally, there are issues associated with both *secondary and vicarious trauma* in small communities where workers can be both related to victims and offenders, or can be the only source of therapy in the area. Individuals in a small community are often aware of charges and/or allegations.

Sadly, for children and families who may already receive ridicule from some community members or kin, their trauma can be further compounded by a lack of safe and private spaces in community to provide therapeutic treatment. As an example, in one community the Health Clinic has been identified as unsafe for therapy by parents as some of the children feel shame and uncomfortable. They have identified the school as a secure place as this allows for confidentiality as the children are simply called to the front office.

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

As we have stated previously in this response, better staffed, informed, responsive and skilled services are what is needed. The comments below address technology as a cheaper (at least in the long run) option to reduce geographic barriers.

- It should not be assumed that all regional people are hesitant to use technology – medical, psychiatric and many other specialties are already using such tools as Skype in remote areas, although many remote Aboriginal people are reluctant to access services via technology where the subject matter is sensitive, such as abuse and trauma.
- While communication technology is improving in some regions where the NBN has been rolled out, extra consideration needs to be given to confidentiality and privacy when child sexual abuse clients want to make use of such resources – technology hubs may need private rooms for such purposes

- Young people in remote and regional communities may be more familiar with and willing to use apps as a means of communicating their issues and receiving information but older people may be more disadvantaged, distressed or confused by such means of speaking to someone.
- There remain strong arguments for initial assessments and regular catch-ups to be done face-to-face as these provide invaluable information not always easy to read.
- Some therapeutic methods could not be used online – for example Eye Movement Desensitisation and Reprocessing
- Upskilling local people for example, shop assistants, hairdressers, mechanics and the like to act as information conduits could assist people seeking information, and could mean that there are alternative sources of information in some otherwise ‘closed’ communities.

#### 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?*

Anglicare WA has few issues with the definitions provided. We would add, as is mentioned above, that advocacy, support even therapeutic treatment can include direct support to family, secondary victims and other supporters *in order to* assist the overall wellbeing of the victim or survivor.

We are particularly pleased to see the words “therapeutic” and “treatment” put together because they imply specific actions on the part of the therapists to impart skills and knowledge to clients and does not imply simply ‘passive’ listening or endless repetition of the facts and little movement towards recovery.

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?*

Practical issues include making sure that therapeutic services are available in a range of venues catering for different groups of clients; inside and outside office hours; in different modes – individual, group work and psycho-education and using a range of therapeutic methodologies including talk therapy, art, bodywork and play therapy especially for children.

Given that research for the Royal Commission has argued for offences to be created to make organisations accountable when abuse occurs<sup>5</sup>, we believe that

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<sup>5</sup> Freiberg, A, Donnelly, H and Gelb, K, 2015 Sentencing for Child Sexual Assault in Institutional Responses to Child Sexual Abuse, Sydney

organisations will not only have to ensure their staff are well trained and tested, but also actively engaged in the discussion about abuse and current treatments regularly.

Unlike many other professions, the helping professions often have to learn on the job with 'live' clients. Despite many years of education, increasing practical experience before graduation, ongoing professional education requirements and regular supervision afterwards, none of these entirely ensure that all workers in an agency are child-safe aware or skilled in providing the support clients need.

Advances in neuroscience are contributing to a better understanding of how workers can be taught academically and on the job to respond more effectively to victims and survivors. For example, Gerdes' et al <sup>6</sup> recent paper on teaching empathy looks at mirror neurones, neuroplasticity, emotion regulation and even mindfulness and argues that these practices should be "a prominent, perhaps even mandatory, component of the social work practice curriculum" (p122).

Other work is being undertaken to ensure that workers in this very sensitive field are the best prepared and equipped to assist clients. For instance research has been conducted by Thomas<sup>7</sup> looking at how to ensure work satisfaction and therefore to help workers to be more effective. Thomas uses Stamm's (2005b) definition of Compassion Satisfaction: "...positive feelings associated with doing helping work effectively" and she notes this influences the quality of decision-making and the development of therapeutic relationships with clients as well as worker satisfaction and retention in the profession (p371).

Such emerging research needs to be rapidly assimilated into tertiary education and workplaces.

Anglicare WA has instituted the idea of consultants in several high value areas including a Children's Consultant, a Domestic Violence Consultant, a Family Law Consultant and an Aboriginal Consultant. These roles, and Practice Leaders, all undertake specialist areas of quality control. The Consultant roles provide support, advice and leadership on matters relating to their specialist areas of expertise. In particular, they provide support with complex case work and ethical dilemmas, and have input into clinical issues that require immediate reporting to statutory authorities. The Consultants also provide leadership and advice on emerging issues, for example, the need for organisations to become safer for children as highlighted by the Royal Commission.

For larger institutions and government departments we also suggest an Internship Consultant to assist, educate and manage new graduates' engagement in

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<sup>6</sup> Karen E. Gerdes , Elizabeth A. Segal , Kelly F. Jackson & Jennifer L. Mullins (2011) Teaching Empathy: A Framework Rooted In Social Cognitive Neuroscience And Social Justice, *Journal of Social Work Education*, 47:1, 109-131 <http://dx.doi.org/10.5175/JSWE.2011.200900085>

<sup>7</sup> Thomas J. (2013) Association of Personal Distress With Burnout, Compassion Fatigue, and Compassion Satisfaction Among Clinical Social Workers in *Journal of Social Service Research* 39:3, 365-379, DOI: 10.1080/01488376.2013.771596

professional skills (for example, intake and assessment skills and specific therapeutic skills) and to provide up to date specialist knowledge that may not have been deliverable in a crowded academic timetable. We envisage this being available to graduates in the first two or so years of their careers.

Consultants and Practice Leaders all help to ensure that the institution does not remain narrowly focussed or insular in its thinking and approaches. And of course, they help to limit the risk of organisations being charged with failure to protect children.

***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?***

A number of professions already ensure that workers are required to document ongoing professional education and supervision but of course practitioners must first join those bodies before they become accountable. A number of professional organisations (including the AASW) have recently been attempting without success to obtain national registration as professions. The intention is to use registration as a means of quality control for professionals. Formal registration would demand higher levels of qualification and experience but of course, may still not entirely ensure that practitioners are the most empathic and skilled people in this difficult arena.

Many therapists working in agencies or in private practice may specialise in working in trauma, including child sexual abuse and they need to be able to have sufficient support to do this well. It is important to find many different pathways to do this – supervision, continuing professional education, on the job training, auditing of practice, provision of employee assistance for staff who need support and who may be looking at vicarious traumatisation from their work.

A number of specific issues arise around trauma when workers from diverse backgrounds elect to assist their own community members. This may apply to workers in Aboriginal and Torres Strait Islander communities, CaLD communities and even some religious or political communities. Workers may have their own experiences of trauma (for example within refugee groups) or be related to, have obligations to and intimate knowledge of, victims, offenders and secondary victims (for example in remote or regional communities). Workers from their own community may be exactly the person to whom a victim wants to talk, knowing that they understand the community and the pressures arising from it, but it is equally true that they may also want the exact opposite – someone who is not connected to the community in any way. Privacy and confidentiality may be the focus of this, concern but there may be other reasons too such as the support given to the offender in the community.

These issues must be identified and addressed by the communities themselves, by the professions and by all of the abovementioned strategies and pathways.

Note, we have not responded to the final three questions.

## Appendix

### *Systemic and cultural factors shaping Advocacy and Support and Therapeutic Treatment Services*

As mentioned in the introduction, Anglicare WA recommends that the responses to the questions be understood within a broader practice context.

#### **Cycles of attention**

The first question about future proposals to prevent child sexual abuse and to work with inevitable victims is how to keep a focus on this particular issue when there are multitudes of issues facing families and individuals and multitudes of professionals engaged for different purposes with families and individuals. The complex nature of child sexual abuse and the factors affecting it is made even more difficult when all these issues are themselves open to numerous points of view and 'well documented' and championed approaches. In the introduction to her ground-breaking work *Trauma and Recovery*, Judith Herman notes that,

The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long. Denial, repression, and dissociation operate on a social as well as an individual level. The study of psychological trauma has an "underground" history. Like traumatised people, we have been cut off from the knowledge of our past. Like traumatised people, we need to understand the past in order to reclaim the present and the future. (p2)<sup>8</sup>

The scope, cost and depth of this Royal Commission obliges us to find some way to keep the issues alive and current for generations to come and in such a way, over time, to reduce the numbers of victims/survivors needing long term support.

#### **Lead times**

Since the 1960s there has been increasing information, research and study in child abuse, neglect and sexual abuse, trauma, neuro-psychology, psychiatry, treatment modalities and methodologies and so on. However there are still numerous graduates in the broadly-defined helping professions in Australia for whom the concept of trauma treatment is relatively new. Obviously many helping professionals might not see it as germane to their primary area of interest (for instance one might think orthopaedic surgeons have more important information to gain but a knowledge of trauma reactions might be critical to assisting many of their patients).

Even if the field is narrowed considerably to focus simply on careers such as counselling, psychology, social work, occupational therapy, youth work and so on, keeping such a vast number of people up-to-date about trauma knowledge will require more than an annual one day workshop. Professional development is an early investment both to the providers and to the recipients.

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<sup>8</sup> Herman JL *Trauma and Recovery; The aftermath of violence from domestic Violence to Political Terror* 1997 Basic Books

### **Competing demands or trends in many fields**

The study of trauma and trauma informed care has been, as mentioned, an increasing trend but it is not the only trend in the field. Similarly there are trends for and against time-limited work and the fact is that they require quite different but not mutually exclusive sets of skills. Many workers in the field understand that time-limited work in the trauma field is a contradiction of terms, however for many years now economics have tended to make an argument specifically for time-limited counselling, especially for those who cannot afford private therapy. Time-limited work does have merit in many areas but at the same time, is difficult in the trauma field. Arguments are made for time-limited work on the basis of responding to demand or to 'prevent' the development of dependency or because of beliefs about models of treatment and because any field in which people provide services, the major cost is in employing people. At the same time, counsellors are often told it is unethical to start work that cannot be finished within a time frame. A compromise may need to be that specific trauma focussed skills can be taught to many clients in a time- limited framework. For instance, aspects of this may be taught in group formats. However for actual amelioration of trauma, as well as recovery, longer term therapeutic treatment is essential.

### **The cost of skill**

Highly skilled therapeutic practitioners should be valued and remunerated accordingly, and in many circumstances cohorts of the helping professions are underpaid. Unintentional though it may be, the poor payment of counsellors and therapists can be read as statement about the diminished importance accredited to this work relative to others, and which in turn can mitigate against the most skilled, interested and passionate people being attracted, retained and developed within this sector.

### **Hidden social costs**

Despite attempts over many years to quantify the social and economic burdens of child abuse and neglect (see for example most recently the research published by ASCA<sup>9</sup>), the community at large fails to understand this basic economic fact – many damaged children will rely on state support for long periods of their lives and many more fail to reach their potential in general. A consequence of this may be that many members of our communities cannot contribute to society as much as they would like. It can be argued therefore that therapists can be seen as making a real contribution to the social and economic wellbeing of the community. The current communal failure to “connect the dots” between abuse and long term economic and social contributions feeds into the scenario of undervalued and poorly remunerated workers assisting the most vulnerable in our community as well as the personal costs for those vulnerable people.

### **The best treatment is the earliest treatment**

Despite the view that many people over the past 30-40 years have taken many years to disclose their abuse, many children during this time have disclosed their abuse immediately and were offered a range of treatments/advocacy and other services.

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<sup>9</sup> Kezelman, C., Hossack, N., Stavopoulos, P., (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*, ASCA and Pegasus Economics , Sydney

"First responders" to disclosures need to know how to respond and what services are available as this is the critical time for the best possible treatment to be offered to children and their families (and for first time offenders too in fact). The sooner children's misunderstandings and cognitive distortions (such as them being responsible for the abuse) are explored by skilled counsellors; the less long term damage is likely to occur. It is at the earliest point that parents (and sometimes wider family, teachers and carers) need information about how best to assist the child and therefore the critical investment in counsellors and advocates should be at this early stage.

### **Offenders need treatment as much as do victims and survivors**

This isn't an argument to see offenders as victims; it is however to acknowledge that some offenders will continue to offend even if all the situational prevention processes possible are put in place. One means of reducing victims is to reduce offenders so highly qualified, very professional therapists are essential to work with offenders.

Although it has rarely happened in Australia in the past, professionals who work with victims and those who work with offenders must share knowledge and expertise for a number of reasons. Firstly treatment of offenders can inform the community and therapists of the tactics offenders use to access and abuse children. Secondly both offenders and victims can become clearer that the offender is responsible for the abuse and thirdly, therapists can be clearer about how offenders 'groom' not only victims and their families but also helping professionals.

### **Family and community support for victims is at least as therapeutic as direct treatment**

Time and effort put into teaching family and community members about trauma-informed care has many benefits: the victim interacts far more with her/his community and family than with a therapist so the more able they are to support the victim, the better; it is a cost effective means of supporting people in the community; it allows specialists to spend more time on the more extreme or more difficult cases and it has the great benefit of embedding into the community more positive attitudes to child safety, disclosures of abuse and the requirements of aftercare for victims.

Accepting all of the above, we will now consider responses to the questions below. In the following comments we have rather arbitrarily used "victim" to refer to children making fairly current disclosures and "survivors" to refer to adult survivors of child sexual abuse some time past.