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Submission : Issues Paper 10. Advocacy and Support and Therapeutic Treatment Services

The Victorian Child Psychotherapists Association (VCPA) welcomes the opportunity to respond to the Issues Paper 10 Advocacy and Support and Therapeutic Treatment Services.

Aim of this Submission

By providing feedback on the proposed questions, the VCPA aims to demonstrate the therapeutic value of making VCPA Child Psychotherapists accessible to children, young people, and their families who have been impacted by institutional child sexual abuse. The VCPA will address the questions of Topic A, B, D and E.

Overview and History of the VCPA

We represent a profession that has a long and proud history that arose out of the Child Psychiatry Training Program run by the Victorian Department of Health.

The VCPA was set up in Melbourne in 1989 by a group of Child Psychotherapists and the Master of Child Psychoanalytic Psychotherapy (MCPP) was offered at Monash University, taught by child psychotherapists, child psychiatrists, adult psychotherapists, psychologists, mental health social workers, and psychoanalysts. It provided specialist training to allied health professionals who worked with marginalised, vulnerable and complex children, adolescents and families. It offered a professional qualification and clinical training of 4 years duration including the completion of a minor thesis.

This course has now been replaced by a Master of Mental Health Science (MMHS) with a Child Psychotherapy specialisation, comprising theoretical studies using a case-based approach to learning. The VCPA provides Masters Students with a comprehensive three-year Clinical Training Program which is completed concurrently with their Masters degree. Completion of this rigorous training and professional qualification leads to eligibility to apply for membership of the VCPA.

The current Masters course and the Clinical Training Program have been offered nationally since 2013, and hence, the VCPA is in the process of changing its name to represent Australia rather than just Victoria.

Child Psychotherapists' Academic and Clinical Training and Areas of Expertise

Child psychotherapy training in Australia is theoretically and philosophically linked to Tavistock and Portman, UK, and its training model.
http://tavistockandportman.uk/training/courses/clinical-training-child-and-adolescent-psychotherapy-m80

All VCPA Child Psychotherapists have completed the Masters Degree in Child Psychoanalytic Psychotherapy (MCPP) or its equivalent through the Faculty of Medicine, Nursing and Health Sciences at Monash University. Prior to commencing the course, all have a minimum of two years professional experience working with children in counseling/therapy, and come from fields such as psychology, social work, medicine, psychiatry, occupational therapy, and art therapy. They have relevant clinical experience with children, adolescents, and families in both short-term and long-term work.

The MCPP and now the MMHS-Child Psychotherapy focus on developing and applying evidence-based best-practice principles in the practice of child psychotherapy. Students undertake practice-based research projects or a minor thesis. Subjects include research in advanced health professional practice and minor thesis, assessment, diagnosis and formulating treatment plans for children and adolescents, theoretical principals of child, adolescent and parent therapeutic work and of short-term therapy and crisis work. The clinical units are taught by experienced Child Psychoanalytic Psychotherapists.
http://www.monash.edu.au/pubs/handbooks/courses/4508.html

In both models of training, Child Psychotherapists have completed a year-long infant observation and associated weekly seminar group, extensive clinical supervision in each of child, adolescent and parent work. Their training includes weekly individual clinical supervision sessions with highly experienced Child Psychoanalytic Psychotherapists over a three-year period. Direct supervision of their own clinical practice totals 300 hours.
http://www.vcpa.org.au/Main.asp?=Membership%20Criteria
http://www.vcpa.org.au

The Professional Standing of the VCPA Membership

The VCPA is a Member Association of the Psychoanalytic Psychotherapy Association of Australasia (PPAA): Link: http://theppaa.com The PPAA works to maintain consistently high professional standards of practice for psychoanalytic psychotherapists across Australia and New Zealand. The VCPA is the only child and adolescent focused therapy association within the PPAA.

VCPA members are required to undertake ongoing clinical supervision

throughout their careers and attend professional development events organised by the VCPA and related organizations.

The clinical and academic training and experience of VCPA members is highly regarded within the health sector. Child Psychotherapists teach and supervise the child and adolescent psychiatry trainees in the RANZCP advanced training, and are sought after for secondary and tertiary consultation across the health sector. VCPA members currently hold senior positions within CAMHS, Take Two, and Berry Street. All these organisations work with children and adolescents with complex psychiatric diagnoses and histories. VCPA members also work in academic positions, other government agencies, hospitals, schools and in private practice.

Areas of Expertise

Child Psychotherapists are valued for their developmental perspective and for the coherent theoretical framework that informs their thinking and their practice. They are also valued for their specialist training and experience as clinical supervisors and senior clinicians. They hold particular expertise in working therapeutically with the most vulnerable and complex children and families within the mental health sector and the child protection system
They are skilled in clinical assessment and diagnosis with presenting problems including post traumatic stress disorder, attachment disorders, anxiety, depression, ODD, ADHD, developmental disorders, ASD, adjustment disorder, and psychosis. They are experienced at working with complex family structures, and with children with a history of abuse, grief, trauma and family violence. VCPA Child Psychotherapists have a long history of being employed by Victorian Centers Against Sexual Assault (CASA), Child and Adolescent Mental Health (CAMHS) services, Take Two, Berry Street, educational settings and in private practice.

VCPA Responses to Topic A, B, D, and E

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?
    - It is essential that therapists providing treatment to this population have the relevant expertise. It is essential that therapists have sound understanding of developmental and trauma theory, specialised skills to work with children, access to regular clinical supervision, and are eligible for registration for their peak body such as the VCPA.
    - Central to recovery of childhood sexual abuse is being safe, being believed and early therapeutic intervention.
        - Therapeutic treatment needs to be predictable and consistent to best manage and create a safe environment

where complex interpersonal themes of trust, shame and complex trauma responses can be processed.

- Interventions need to be easily accessible to all, and enable children and young people to return to treatment at different developmental stages.
- Therapy with Children and Adolescents requires a specialised skill set that can utilise modalities such as play and art, so that children can express themselves in safe and developmentally-relevant ways. Adult approaches to treatment, and treatment provided by clinicians who do not have specialised skills in working with children and adolescents is likely to be unhelpful and could re-traumatise.

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?
    - Delay in access to services
    - Inadequately-trained therapists. Therapists working with children who have no specific training to do so.
    - Inability to access services; e.g. lack of finance; waitlists in the public sector.
    - 10 session Medicare model. 10 sessions is grossly inadequate for a significant proportion of people impacted by childhood sexual abuse. Central to recovery from sexual abuse is the development of trust and establishment of safety. This primarily occurs over a longer-term therapeutic relationship. This process is undermined by a 10 session model as many victims/survivors are not able to fund further sessions. In addition, the Medicare model currently does not provide financial support to access child psychotherapists.
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?
    - Access to allocated funding (such as in a victims of crime compensation framework (VOCAT)), that they can readily access at different life stages. This model could utilise a pool of specialised clinicians with experience in the area of trauma and childhood sexual abuse, including child psychotherapists.
    - Better funding of public sector to provide longer-term therapeutic interventions to children and young people.
    - Overwhelmed public sector, leading to waitlists to access a service up to 9 months, and regularly can be up to 4 months.
    - Silo funding model which inhibits flexible practices.
    - Services (including Government agencies such as Child Protection and the Courts and non-government agencies) that fail to acknowledge, understand, or act in the best interests of victims/survivors of sexual abuse. In particular, vulnerable populations such as people with a disability; people for whom English is not a first language; infants; and children.

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?
    - Children of survivors of childhood sexual abuse can be a vulnerable population due to the impacts of sexual abuse on intimate and caring relationships. The intergenerational impacts of childhood sexual abuse, in particular where the victim was not believed, not supported, and not protected from harm, can lead to long-term mental illness that can dramatically impact on parenting skills. This intergenerational trauma, when gone untreated, can contribute to dynamics of risk of further harm occurring in future generations. We would like to see a model such as that used in Veteran Affairs, in which the children and family members of war veterans and peacekeepers can access unlimited therapy sessions as the model acknowledges the intergenerational impacts of PTSD.
    - Secondary victims such as siblings, parents, non-offending staff, and peers can be greatly impacted by institutional abuse, as there has been a profound abuse of trust and power that affects whole communities. It is important to consider that sexual abuse can often exacerbate current stressors in family relationships and communities. If not properly supported, these can become irreparable and impact on future generations.
    - Those with their own prior history of sexual abuse can also be impacted by learning of the sexual abuse of a family or community member. This can be a complex dynamic that may require short, medium, or long-term support to recovery from the primary and secondary traumas of their own sexual abuse history and that of someone in their family or community.
    - When families and communities are not adequately supported, themes of secrecy and shame can persist and create a dynamic where divisions can occur, and sexual abuse can reoccur.

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?

- Diverse victim/survivors can include:
    - Indigenous Communities
    - Children, young people and adults with special needs/physical or intellectual disabilities/mental illness/substance abuse issues/homelessness
    - LGBTI Community
    - CALD communities
    - Young people in the Juvenile Justice system

- Children & young people in residential care
- Children & young people in Detention
- Most diverse victim survivors are provided services within generalist sexual assault services such as the Victorian CASA model.

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?
    - Providing better opportunities to train and/or up skill clinicians from specific communities to assist the development and provision of therapeutic services for victim survivors. For example; providing better opportunities of pathways for training and higher education to people from an aboriginal, CALD background.
3. What would better help victims and survivors in correctional institutions and upon release?
    - Relationships built with therapists and other relevant support services prior to release and continued for the medium longer term post release.

Topic D: Service system issues

1. -
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?
    - Greater funding to provide more therapists in the public sector so a significant reduction of waitlists can occur.
    - As written in point A3, establishing a system for victim survivors, such as VOCAT where an individual and/or secondary victim is provided with adequate funding to access trained, specialised therapists such as VCPA Child Psychotherapists. This funding should be made available at different life stages; including, childhood, adolescence and adulthood.
    - As written in A4, a model of therapy provided to secondary victims such as in Veteran Affairs where children and family members of return soldiers have unlimited opportunity to access therapy.

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?
- To establish a post graduate certificate for generalist therapist who work with child and adolescent trauma and sexual abuse. This certificate be informed by trauma, attachment and developmental theory.
- Professional Registration bodies such as the VCPA ensure regular professional development in the areas of working therapeutically with

children, adolescents, adults and their families impacted by sexual abuse and intergenerational trauma.

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?
   - In recent years there has been an increase in the research focus on evaluating practices of Child and Adult Psychoanalytic Psychotherapy. There is now extensive evidence-based research on the efficacy of the work in both short-term and long-term work. The research compares child psychoanalytic psychotherapy to other therapies such as CBT and findings have been favorable. It can be a therapy of choice when other therapeutic approaches have been unsuccessful. It can be successful when compliance is a problem. Psychoanalytic therapies have the potential to affect long-range vulnerability by altering the way the patient deals with stressors and therefore to make more enduring changes. For these reasons it can in fact be a cost effective treatment especially for the most complex and vulnerable children and families. See Fonagy et al (2015) this 2nd edition. What Works for Whom? Has included a chapter on Child Maltreatment. pp 411-451 and Summary pp 471-474.
   - There is also much evidence to support the efficacy of Psychoanalytic Psychotherapy in Neuroscience, which is offering new understandings of the neurobiological processes at play during normal and disrupted development and in effective psychotherapy. (see included reference list)

2. What evaluations have been conducted on promising and innovative practices? what have the evaluations found?
   - 'There is specific support from meta-analyses for psychotherapy, group treatment, and CBT combined with supportive, psychodynamic, or play therapy. Play therapy on its own does not seem to be effective. In the case of psychotherapy, overall outcomes and symptoms of PTSD were found to improve the most; moderate improvements were found for internalizing and externalizing symptoms; self-esteem, and sexualized behaviour; and there were small to moderate improvements in coping and social skills. One meta-analysis, which looked at a range of treatments, found that longer treatments and more sessions produced larger effects, and older girls who had experienced sexual abuse within the family benefited more' (p472). Fonagy, P., Cottrell, D, Phillips, J., Bevington, D., Glaser, D., and Allison, E. (2015). What Works for Whom? (Second Edition): A Critical Review of Treatments for Children and Adolescents. Guilford Press. New York.

- There is now evidence that adults with treatment-resistant depression do very well with psychoanalytic psychotherapy: Fonagy, P., Rost, F., Carlyle, J., McPherson, S., Thomas, R., and Fearon, R. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: The Tavistock Adult Depression Study (TADS). *World psychiatry: official journal of the World Psychiatric Association (WPA)*. *14*(3):312-21. DOI: 10.1002/wps.20267

3. What other learning's 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?

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Yours Sincerely,

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