

## Response to Issues Paper 10 Advocacy and Support and Therapeutic Treatment Services (Released 1 October 2015)

**About ASCA:** [www.asca.org.au](http://www.asca.org.au)

ASCA is the leading national organisation supporting the estimated five million Australian adults who are survivors of childhood trauma, including abuse, their families and communities. ASCA has been providing specialist services to adult survivors of childhood trauma (in all its forms) for 20 years. It provides hope, optimism and pathways to recovery for those affected.

ASCA is fully conversant with current clinical insights in relation to effective and innovative practice and is recognized as a pioneer in this regard.<sup>1</sup> At the forefront of pioneering trauma informed policy, practice and research, ASCA has been instrumental in supporting the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and people engaging with it. This includes the training of key workers and practitioners.

In 2012 ASCA released *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*<sup>i</sup>, a global first in setting the standards for clinical and organisational practice. In 2015 ASCA released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*<sup>ii</sup>, leading the conversation around the economic imperative of providing the right services for adult survivors.

Formed in 1995, ASCA provides a range of services including professional phone support with trauma informed counsellors, a referral database, resources, research, educational workshops for survivors and family members, partners and loved ones, along with training, professional development and other services for workers, organisations and professionals, including those from health and legal sectors.

ASCA is also a prominent advocate for system changes to see the complex needs of adult survivors of childhood trauma better met. Its place in the landscape of advocacy, direct service provision, policy, practice, and workforce development is critical to ongoing sector and service development.

---

<sup>1</sup> ASCA's *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* are nationally and internationally endorsed by experts in the complex trauma field. They were presented by invitation at the 29<sup>th</sup> Annual Conference of the International Society for the Study of Trauma and Dissociation (ISSTD) in October 2012 and subsequently launched in the Australian Federal Parliament by then Minister for Mental Health Mark Butler.



## **ASCA RECOMMENDATIONS**

### **Recommendation 1:**

*The collective voices of government and non-government agencies as well as of practitioners who work with survivors play a critical role in advocating for the needs of those who were disempowered in childhood and, in many cases, rendered voiceless then and now. Policy, practice and systems of support must be informed by survivors, in the first instance but also by the practitioners and agencies who work with them.*

### **Recommendation 2:**

*Systems need to be established whereby survivors and/or their advocates can present their individual needs - those needs can be assessed and the trauma-informed services required to best meet them, are identified, accessed and coordinated. In many cases a case manager would be required to help coordinate the services needed to assist people in their daily lives.*

### **Recommendation 3:**

*Systems of care for survivors of institutional child sexual abuse need to support and address survivors' diverse daily needs of living. These must be informed by survivor choice and knowledge as well as awareness of the impacts of compounded traumas, challenges to help-seeking capacity and increasing age.*

### **Recommendation 4:**

*Relationally-based and phased treatment approaches which engage the body, mind and emotions ('bottom up' as well as 'top down') and prioritise safety and stabilisation are recommended. The principle that effective therapy for childhood trauma is not achievable within 8-10 sessions needs to be acknowledged at the outset, and the nature and provision of psychological services structured to meet the generally longer courses of treatment required. Therapeutic treatment may be accessed episodically or regularly for a sustained period determined by client need and desire.*

### **Recommendation 5:**



*Practitioners providing therapeutic treatment require adequate knowledge, experience and skills in supporting people who have experienced complex trauma, including child sexual abuse. (Standard PTSD treatment (i.e. for 'single-incident' trauma), short-term and predominantly cognitive therapies (notwithstanding the strong evidence base for the effectiveness of cognitive behavioural therapy; 'CBT') are not adequate in the absence of attentiveness to and ability to address 'right brain' functioning and self-regulatory deficits.)*

**Recommendation 6:**

*Survivors of childhood trauma and sexual abuse need access to ongoing, affordable Services which are trauma-informed and which offer appropriate support at any period during the life-cycle.*

**Recommendation 7:**

*Referral pathways need to be streamlined (so that there is 'no wrong door'); psycho-education needs to be readily available, and all service-providers (i.e. not just clinical staff but personnel of all advocacy, support and other services) need to be fully conversant with ways of operating which reduce the potential for overwhelm and re-traumatisation.*

**Recommendation 8:**

*ASCA recommends the establishment of a centralised agency to oversee and coordinate the introduction of minimum standards and the necessary intersectoral links, and with which various stakeholders would register (even as the range of services involved would operate according to their more specific and particular needs). This agency could facilitate research, collaboration and referral pathways.*

**Recommendation 9:**

*The introduction of trauma-informed practice is made mandatory within all current and future services to which adult survivors present, and barriers and structural disadvantages currently experienced are identified and addressed.*

**Recommendation 10: 'No wrong door'**

*Education and trauma-sensitive training of primary care practitioners across Australia should be prioritised to facilitate survivors receiving appropriate support. Such support may be direct or via targeted referral (including specialist counselling/therapy from an accredited and/or appropriately qualified practitioner).*

**Recommendation 11:**

*Universal trauma screening which is aligned to preventative health screening should be developed and implemented throughout the Australian primary care system.*

**Recommendation 12:**

*Trauma-informed practice is the gold standard and orienting principle within all mainstream services irrespective of their structure and form of support and therapeutic services provided to survivors.*

**Recommendation 13:**

*Integrated training programs for staff and practitioners around trauma-informed practice and vicarious trauma which include mechanisms for ongoing quality assurance need to be mandated.*



**Recommendation 14:**

*Survivors, survivor groups and specialist services which are centres of excellence for supporting adult survivors are best positioned to spearhead policy and practice initiatives. Active investment is needed to support a coordinated comprehensive model of care including continued and increased availability through effective phone lines and online services.*

**Recommendation 15:**

*All practitioners supporting or providing therapeutic treatment to survivors must be specifically trained to deal with the complexity of the issues involved. Such services need to be accessible and affordable throughout Australia. Widespread investment in training supported by a program to accredit practitioners of a range of disciplines is also recommended - appropriate training and regulation of practitioners is critical.*

**Recommendation 16:**

*The need for specialist services informed by survivor experience, and which combine clinical, research and academic expertise, and which are dedicated solely to the needs of adult survivors, cannot be overstated.*

**Recommendation 17:**

*Trauma-informed practice needs to be embedded within and across services in all services and at all levels of operation for the benefit of family and friends as well as 'secondary victims' more broadly.*



**Recommendation 18:**

*Workforce development which includes ongoing quality assurance is needed for diverse staff and support workers, clinical and non-clinical.*

**Recommendation 19:**

*A service system which recognises and addresses diversity including ethnicity, race, language, place, age, sexuality, gender, intellectual and physical ability as well as geography is needed. It is important for all service options to be communicated to those seeking support and therapeutic treatment services.*

**Recommendation 20:**

*Funding for the requisite service system to meet the needs of all survivors including those from diverse groups is commensurate with complex, diverse, sustained and ongoing needs.*

**Recommendation 21:**

*Coexistence of trauma-informed practice and attunement to diversity in all its forms must be a best-practice requirement of all services at all levels of operation if the needs of survivors of diverse backgrounds and contexts are to be effectively met.*

**Recommendation 22:**

*Comprehensive web-based and call-in trauma-informed services need to be provided to survivors in regional and rural who are unable to access face-to-face services.*



**Recommendation 23:**

*Because abuse trauma can affect many aspects of a survivor's life, coordination across systems is essential. Supporting survivors requires specialist knowledge and understanding of trauma - its effects and dynamics, workforce education and training, and collaboration between survivors, family members, policy makers, and service providers.*

Response comprises (A) General comment  
(B) Specific remarks on the designated areas

---

## **A. GENERAL COMMENT**

Currently in Australia:

- Child sexual abuse (and complex trauma in general) and its effects are often unrecognized, misdiagnosed and unaddressed
- people impacted by trauma present to multiple services over a long period of time; care is fragmented with poor referral and follow-up pathways
- a 'merry go round' of unintegrated care risks re-traumatization and compounding of unrecognized trauma
- escalation and entrenchment of symptoms is psychologically, financially and systemically costly

**We know that trauma is not simply an individual misfortune; rather, it is *a public health problem* of major proportions.**

**Responding to the public health challenge of complex trauma:**

- requires *integration of vision and research into practice*
- means engaging an *array of services and professions to achieve a paradigm cultural shift in mental health and human service delivery*
- requires *specialised knowledge, workforce education and training, and collaboration* between consumers, carers, policymakers, and service providers.
- necessitates *national training programs* for systemic quality improvement, cultural reorientation and workforce development.<sup>iii</sup>





## **MANDATED REQUIREMENT:**

### **ALL SERVICES TO OPERATE ON A TRAUMA-INFORMED BASIS**

*'Without such a shift [towards trauma-informed practice] ...even the most 'evidence-based' treatment approaches may be compromised' (Jennings, 2004).*

In addressing the impacts of child sexual abuse on their lives, survivors should have access to a range of services. These services may vary considerably, and include those of advocacy and support as well as those for therapeutic treatment.

An important common feature of all such services however (i.e. notwithstanding what may otherwise be significant differences between them) is that *all services with which survivors of childhood trauma come into contact should be trauma-informed*. As such, they should operate according to the core principles of trauma-informed practice; i.e. *safety, trustworthiness, choice, collaboration and empowerment* (Fallot & Harris, 2009; Jennings, 2004).

It is important for all involved in support, advocacy or therapeutic roles to have knowledge and understanding about the effects of overwhelming stress on the brain and body, especially if it occurs in early life (i.e. need for dissemination of a trauma-informed perspective).

'Trauma informed' is not a particular modality of treatment. Nor does it relate only to clinical practice. Rather it is *the foundational basis from which all contact – clinical and non-clinical - with trauma survivors should proceed*. Research in trauma-informed practice is unequivocal that unless specific and otherwise contrasting services are underpinned by trauma-informed principles, *'even the most 'evidence-based' treatment approaches may be compromised'* (Jennings, 2004).

This means that trauma-informed practice is not an 'optional extra' and is not one approach or modality among many. To regard it in this light is to fail to understand both the breadth and wide applicability of the paradigm shift it comprises.

Insistence that ALL services with which survivors come into contact should be trauma-informed is not to homogenise services which may otherwise, and legitimately, remain diverse. Nor is it to deny choice to survivors who may wish to access different services simultaneously or at different times (indeed 'choice' is a core principle of trauma-informed practice). This is because *the research substantiates that widespread implementation of trauma-informed practice within and across services is consistent with the principles of trauma recovery*.

This is not the place for full discussion of the principles of trauma-informed practice (i.e. which should inform *all services, irrespective of type*, with which survivors of child sexual abuse come into contact). Guidelines in this area are downloadable at [www.asca.org.au/guidelines](http://www.asca.org.au/guidelines) (second set of guidelines). Trainings in trauma-informed practice for staff at all levels of diverse organisations, agencies and services as well as consultancy to help embed it across organisations and systems are available and much needed for systemic implementation.

The key point to note is that the basic principles of trauma-informed practice (which relate to *minimisation of harm* and *reduction of the risk of compounding prior trauma*) are *accessible to all parties and personnel*. This is irrespective of qualifications, experience and skill-base (by contrast, *therapy and clinical treatment* of survivors of childhood [complex] trauma is specialised and requires appropriate qualifications and experience; see the first set of ASCA Guidelines; *ibid*).

Central to trauma-informed practice is:

- (1) basic knowledge of the effects of stress on the brain and body
- (2) attention to *the way in which* a service is provided (i.e. not just *what* the service is)
- (3) relating to clients/patients from the perspective of what may have *happened to* them (rather than what is 'wrong' with them).

It is well within the capacity of all services and diverse personnel to acquire working knowledge of the core principles of trauma-informed practice (which are highly effective in reducing stress not only for clients/patients but for their service-providers and care-givers).

Trauma-informed practice is cost-effective and simple to learn and implement once the basic training has been undertaken. While comprehensive 'systems change' of course requires time, there exist a range of easily enacted measures which can be readily incorporated into daily service practice.

Given the strong research base on which trauma-informed practice now rests (and which establishes the neurobiological benefits of relational interactions which are soothing and validating rather than disruptive and stressful; Siegel, 2009; Doidge, 2007; Cozolino, 2002) *all services of all kinds* need to operate from this basis in order to maximise benefits for, and reduce inadvertent harm to, survivors of childhood sexual abuse and trauma in all its forms.

*"Many of the complex callers who call us report a history of being re-traumatised by mental health services and being asked to leave or be 'banned' from services for 'being too difficult'. They also report that mental health services respond to their symptoms in a way that does not acknowledge their trauma. They liken this to being treated for 'what's wrong with them' as opposed to 'being treated for what happened to them'. At ASCA we use a model that looks at symptoms through the lens of what happened to them, so all intervention is conducted in a trauma informed manner. Many callers find this a relief and then seek to call us back and gain more ongoing support from us."*

ASCA - Teleweb Evaluation Report 2015

## **B. RESPONSE TO DESIGNATED AREAS**

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

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

Victims and survivors have diverse and often complex needs; historically these needs have been poorly met or chronically unmet. The needs of survivors of historical institutional child sexual abuse have compounded over time and the impacts of their unresolved trauma have become cumulative. The importance of meeting the needs of survivors of institutional child sexual abuse has never been more acute, as the challenges of ageing further complicates the lives of those whose trauma remains unresolved.

The fundamental principles of trauma-informed practice – which form the cornerstone of basic human rights - have been violated for survivors of institutional child sexual abuse by their abusers. Thus it is critical that the core principles of trauma-informed practice are embedded within and across advocacy, support AND therapeutic treatment services.

Although the terms of the Royal Commission into Institutional Responses to Child Sexual Abuse restrict its purview to child sexual abuse within that domain the point needs to be made that child sexual abuse rarely if ever occurs in isolation. As repeated testimony to the Commission attests, gross neglect, deprivation, brutalisation and violations have occurred within institutions, alongside sexual abuse and/or separately and multiple abuses have often been perpetrated with impunity.

It must also be noted that occurrences of child sexual abuse, specifically and childhood trauma, generally are not limited to the institutional context. While not within the terms of reference, it is important to state that all forms of abuse, neglect and other adverse childhood experiences occur and are perpetrated within the home, neighbourhood and diverse community settings.

Systemic advocacy, as has been, and continues to be required for survivors of institutional child sexual abuse, is similarly required for all survivors of all forms of childhood trauma in all domains. In fact such advocacy is critical to drive the change needed for the large numbers of Australians impacted - an estimated 5 million Australian adults - to access to pathways to recovery. Only through sustained advocacy and systems' change will this group of Australians receive the supports and therapeutic treatment they need to live healthy connected and constructive lives.

Frequently survivors, silenced at the time of their abuse, further silenced in systems of justice, care and support, and again through societal stigma, do not have the capacity to advocate for their individual needs and/or to access or afford the support and therapeutic treatment they require for their needs to be addressed.

**Recommendation 1:**

*The collective voices of government and non-government agencies as well as of practitioners who work with survivors play a critical role in advocating for the needs of those who were disempowered in childhood and, in many cases, rendered voiceless then and now. Policy, practice and systems of support must be informed by survivors, in the first instance, but also by the practitioners and agencies who work with them.*

*“I am so thankful and happy to know that you and the people you work with and gather around you are there to help us, to offer support, education and most importantly a voice. A real, educated, rational, honest, non-deniable voice. I feel that my prayers have been answered, granted. The very fact that ASCA exists takes me and all of the human beings who have experienced childhood abuse out of the darkness and into the light. Most importantly ASCA is giving us a voice, legitimacy. A real, educated, rational, honest, non-deniable voice. Thank you, thank you, from all that I am, I thank you.”*

Early understanding and identification of the impacts of prior trauma, and appropriate responses to it, can reduce the huge budgetary, economic, health and social costs associated with childhood trauma and abuse. It can also substantially improve the health and happiness of the individuals, families and communities directly and indirectly affected i.e. increases national well-being.<sup>iv</sup>

Being able to access the right services at the right time is critical to the health and well-being of each survivor.

*“ASCA has led the way in defining best practice through developing the internationally acclaimed ASCA’s Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Caring for this group of people in our society needs greater awareness of the particular issues – issues that make them less likely to self-present, and to seek medical care, and the delicate task of engaging them in treatment that has the potential to be life giving to both them and their families.”*

Australian General Practitioner, Dr Johanna Lynch<sup>v</sup>

## Recommendation 2:

*Systems need to be established whereby survivors and/or their advocates can present their individual needs - those needs can be assessed and the trauma-informed services required to best meet them, are identified, accessed and coordinated. In many cases a case manager would be required to help coordinate the services needed to assist people in their daily lives.*

*“Trauma survivors still experience stigma and discrimination and unempathic systems of care. Clinicians and mental health workers need to be well informed about the current understanding of trauma and trauma-informed interventions.”*

<sup>vi</sup> Professor Louise Newman Psychiatrist, Director, Centre for Developmental Psychiatry and Psychology, Monash University

All services need to recognise the extreme disadvantage to which many survivors were exposed and its impacts on their capacity to seek access and sustain support. Notably, this includes *‘the way people approach potentially helpful relationships’* (Fallot & Harris, 2009:2). Particular difficulties in seeking help and negotiating systems of care can be experienced as a result of institutionalisation. These are both additional to and compounded by the child sexual abuse experienced alongside other violations and deprivations. If the legacy of these dynamics is not understood by service providers, the potential for negative experiences and active re-traumatisation by and within services will remain high (*‘[t]rauma has often occurred in the service context itself’* [Jennings, 2004:6]).

While therapeutic treatment needs are critical, so, too, is enabling access to the social, health, dental and legal supports needed by survivors of institutional child sexual abuse. Survivors experience multiple diverse challenges across the life cycle and have different needs at different times. These include but are not limited to practical issues of housing: homelessness, risk of homelessness, difficulties accessing permanent housing, poor or limited education, challenges with employment, welfare dependency, mental and physical health issues, substance abuse, parenting and intergenerational problems, situations of re-victimisation and domestic violence, isolation, shame, issues of identity and relationship challenges.

The need for individual and collective advocacy cannot be understated and this includes the role of organisations representing survivors generally and survivors within institutional settings specifically.

As previously indicated it is important for all support services and organisations working with victims and survivors to be predicated on the core trauma-informed principles of *‘safety’, ‘trustworthiness’, ‘choice’, ‘collaboration’ and ‘empowerment’* (Fallot & Harris, 2004; Jennings, 2004, 2009). While seemingly simple and unexceptionable, research shows that these principles are not routinely or even frequently operationalised by diverse services with which survivors come into contact.

As regards support and therapeutic treatment services: *'The first task is to support and improve the functioning of the survivor... in daily life'*<sup>vii</sup> People will often respond better to treatment when they are empowered in ways that are unique to them and when they are active participants in their own care. Professionals and institutions should not underestimate the patient's ability to be very useful and active in their own treatment.<sup>viii</sup>

### **Recommendation 3:**

*Systems of care for survivors of institutional child sexual abuse need to support and address survivors' diverse daily needs of living. These must be informed by survivor choice and knowledge as well as awareness of the impacts of compounded traumas, challenges to help-seeking capacity and increasing age.*

Diverse therapies and treatment approaches are applicable for survivors of childhood trauma to the extent that they engage the relevant neurobiological processes and are based on foundational knowledge of the core features of complex trauma. ([www.asca.org.au/guidelines](http://www.asca.org.au/guidelines))

Current research attests both to the importance of the relational connection between client and therapist in effective treatment of complex trauma and the need for practitioners to be knowledgeable and skilled regarding the specific nature of interpersonally generated trauma and abuse.

The extensiveness of the impacts associated with complex trauma means that three phases of treatment are recommended<sup>ix</sup>:

- (1) Stabilisation, resourcing and self-regulation
- (2) Processing of traumatic memories which, because unassimilated, impede integrated functioning and quality of life
- (3) Consolidation of treatment gains towards optimal re-engagement in relationships, work and life.<sup>x</sup> (Also see 'Treatment approaches' below)

The key initial goal is *'to support and improve the functioning of the survivor...in daily life'* (van der Hart et al, 2006:304) which corresponds to the first phase of safety and stabilisation.

Exploration of memories of the trauma of child sexual assault (second phase) is dependent upon the safety and stabilisation skills acquired in phase one - *'The success of therapy, especially with [clients] who have been traumatised, hinges on our ability to accurately read and effectively modulate their levels of physiological arousal as well as their needs for (and fears of) relational engagement'* (Wallin, 2007). The latter highlights the need for *'a focus on the body, nonverbal experience, and the nuances of the therapeutic interaction'* (ibid). The value and need for exploration of detailed memories of the trauma of child sexual assault must be driven by the client, and is only helpful if that is the case.

With respect to 'what works' regarding therapeutic treatment services, we know that complex trauma treatment is *generally longer than that for other presentations* and *phased* in approach. This need relates to the extensive neurobiological impairments associated with childhood trauma. The rationale for generally longer treatment than for other presentations is also based on expert consensus recommendations for treatment in the complex trauma field. Treatment for clients with personality disorders and dissociative disorders is likely to be far longer than for many other presentations.

Significantly, a majority of experts in a survey of specialists regarded 6 months as a reasonable length of time for Phase 1, 3-6 months for Phase 2 (thus a combined treatment duration of 9-12 months for the first two phases) and flexibility around Phase 3 in which sessions could be tapered over time according to client needs over a 6-12 month interval. This constitutes recommendation for longer courses of treatment than have been applied in clinical trials. Duration of the intensive treatment phases (Phases 1 and 2) may also be significantly longer than the estimated 12 months noted above (note that a degree of flexibility is required for all phases, which for many reasons will rarely be strictly linear). For severely impaired patients, treatment of several years may be necessary and/or may be required intermittently over the individual's lifetime.<sup>xi</sup>

Therapists also need to be aware of differences in client capacity to engage in therapy and to resolve their symptoms and distress. Survivors of institutional child sexual abuse have different degrees of self and relational impairment, and so of their capacity and resources for recovery. Where survivors themselves may be unable or unwilling to engage in therapy to its full extent, there are strong grounds to confine the focus of therapeutic work to the 'Phase 1' (stabilisation) stage.

Therapy is recommended to occur on a once or twice-weekly basis, with sessions ranging between 50 and 75 minutes for individual therapy and between 75 and 120 minutes for group therapy (although there exist instances in which 'more sessions per week are obviously needed').<sup>xii</sup> Exceeding these recommended standards of frequency in the absence of compelling grounds for doing so needs to carefully consider the risks of inadvertent destabilisation and dependence.

There is an acute need to identify and train clinicians and practitioners with the skills to work in the manner outlined above.

#### **Recommendation 4:**

***Relationally-based and phased treatment approaches which engage the body, mind and emotions ('bottom up' as well as 'top down') and prioritise safety and stabilisation are recommended. The principle that effective therapy for childhood trauma is not achievable within 8-10 sessions needs to be acknowledged at the outset, and the nature and provision of psychological services structured to meet the generally longer courses of treatment required. Therapeutic treatment may be accessed episodically or regularly for a sustained period determined by client need and desire.***

## 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 phenomenological Australian study (Valencia et al, 2014) investigated the components which either contributed to healing or, alternatively, to negative experiences during either individual or group counselling for child sexual assault in both men and women. The associated peer-reviewed article identified four key themes: factors relating to *the abuse, the client, the practitioner*, and to *the counselling itself*.

With respect to the practitioner, 'the way in which the practitioner was with [clients]: their being with them' and a process focussed on the client which was reflective and challenging when needed were found to be important. The development of trust through *consistency of care, safety; provision of hope for healing; non-judgemental acceptance*; and *practitioner knowledge about child sexual abuse and its impacts* were core elements.

Approximately half of a research sample reported negative or unhelpful experiences in counselling, which often resulted in the client departing from therapy with the counsellor concerned. Some of these instances were 'assault-specific' and included negative responses to disclosure, encouragement to convey details of the trauma when they didn't want to, and, notwithstanding presenting with depression, anxiety or relationship issues, not being asked about prior experiences of abuse. Other negative experiences were practitioner-specific, and included challenges in developing rapport when practitioners seemed overly involved or distant, were unable to hear elements of the trauma and/or unaware of what was required to support survivors (ibid).

For survivors, lack of capacity to have their voices heard in relation to the treatment/service they receive (a sense of being 'done to' rather than a sense of being active collaborators in their own recovery) is not optimal. As noted previously, survivors '*will often respond better to treatment when they are empowered in ways that are unique to them...professionals and institutions should not underestimate the patient's ability to be very useful and active in their own treatment*'; Stillwell, 2012:viii).

Failure of a service/treatment to actively engage with survivors regarding the service/treatment they receive violates a core principle of trauma-informed practice (i.e. collaboration). It also places the survivor in a passive position. This not only violates another key principle of trauma-informed practice (i.e. empowerment); it also risks re-traumatization of survivors by replicating the dynamics of the trauma from which they are seeking to heal.

### Recommendation 5:

*Practitioners providing therapeutic treatment require adequate knowledge, experience and skills in supporting people who have experienced complex trauma, including child sexual abuse. (Standard PTSD treatment (i.e. for 'single-incident' trauma), short-term and predominantly cognitive therapies (notwithstanding the strong evidence base for the effectiveness of cognitive behavioural therapy; 'CBT') are not adequate in the absence of attentiveness to and ability to*



*address 'right brain' functioning and self-regulatory deficits.)*

We know that *'many survivors have been retraumatized by [health professionals] who had inadequate understanding and skills to treat complex trauma-related problems'* (van der Hart et al, 2006: 224). While trauma-focussed therapies, uninformed by knowledge of *complex* trauma, can help alleviate distress, anxiety and depression in child sexual assault <sup>xiii</sup> they have not been established to improve interpersonal and social functioning which are fundamental impacts of child sexual abuse. <sup>xiv</sup>

Therapeutic approaches which do not address social and interpersonal functioning are less effective. Exposure-based therapy for survivors has been shown to have higher drop-out rates (Davis et al, 2006) than, for example, present-based therapy which focuses on the negative self-beliefs and maladaptive interactions which connect present day functioning to prior trauma: *'[e]ffective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma'*; van der Kolk, 2003: 173; McDonagh et al, 2005).

Institutional child sexual abuse -as is common to other adverse childhood experiences related to complex trauma - is *relational* trauma. Much of our research, however, consistently focusses on interventions suited to the returned soldier or accident victim (who may not necessarily experience relational trauma as an adult) or to 'single incident' interpersonal trauma (i.e. sole instances of sexual or physical assault as an adult).

*"We are on the verge of becoming a trauma informed society. Almost every day a report is published showing how trauma disrupts the workings of mind, brain and body....Advances in neuroscience have given us a better understanding of how trauma changes brain development, self-regulation and the capacity to stay focussed and in tune with others.... (However) discussions of PTSD still tend to focus on recently returned soldiers, victims of terrorist bombings and survivors of terrible accidents. But ... since 2001 far more Americans have died at the hands of their partners or family than in the wars...."*<sup>xv</sup>

Despite our increasing knowledge of the negative -even catastrophic - impacts of attachment disruption in childhood, many scientists and practitioners assume that interventions for adult onset trauma are necessarily also applicable to those who experience trauma in a relational context. Increasingly we are learning that this is not the case. Treatment interventions which ignore *the attachment damages that are specific to those who experience relational sexual abuse from care-givers* are destined to be ineffective and, at worse, may even be damaging (van der Kolk, 2003).

The particular dynamics of *complex* trauma (i.e. which is experienced by survivors of child sexual abuse if the trauma has not been resolved) mandate *a different treatment path than that for 'single incident' trauma (i.e. PTSD)*. It is vital this point is understood by treating practitioners, because survivors *'may react adversely to current, standard PTSD treatments'* which prioritise exposure and processing over acquisition of the self-regulatory skills which complex trauma disrupts (van der Kolk, *ibid*:173): *'In contrast to the traumatized person who has experienced a sense of safety and well-being prior to onset*

*of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage'* (Shapiro, 2010).

The ISTSS developed guidelines for the treatment of PTSD in 2000. The revision in 2008 acknowledges that the PTSD framework does not adequately address the symptoms and problems of those exposed to prolonged child sexual abuse.<sup>xvi</sup> The ISTSS task force definition of Complex PTSD includes not only PTSD but also (a) *emotion regulation difficulties*, (b) *disturbances in relational capacities*, (c) *alterations in attention and consciousness* (e.g., dissociation), (d) *adversely affected belief systems*, and (e) *somatic distress or disorganization*. Other international experts also note that severe, repeated and prolonged trauma (such as child sexual abuse) is more strongly associated with disturbance to affective regulation, self-construct and interpersonal relations than is adult onset, single incident PTSD.<sup>xvii</sup>

## **Treatment approaches**

In a report on a survey conducted by the ISSTS, 84% of clinicians, expert in either the treatment of complex PTSD or PTSD clients endorsed a phased approach.<sup>xviii</sup> This approach is also endorsed by a number of key international bodies.<sup>xix</sup>

A study comparing a phase-based treatment (skills training followed by memory processing) to exposure-focused treatment and to a skills focused treatment indicated the superiority of the phase-based approach over the skills based approach *with the exposure-focused treatment performing least well.*<sup>xx</sup>

Crucially, the specific negative effects of complex trauma (i.e. disturbances to *affective regulation, self-construct* and *interpersonal relations*) are more likely to be pervasive, long lasting and 'treatment resistant' (where the latter term is inappropriate to the extent that recommended treatment for *complex* trauma-related problems is different than that for single-incident trauma [PTSD]) As noted above, treatment is likely to be far longer than the 9-12 sessions referenced in the Cloitre et al study of 2011. Hence the need for attentiveness to the *type* of trauma (i.e. single-incident or complex) in all studies of treatment effectiveness.<sup>xxi</sup>

As previously noted studies comparing the treatment response of adult onset PTSD with that of complex PTSD that results from childhood events typically find that treatment takes longer for those who have experienced relational ruptures from childhood. *This important qualification applies to therapies which are found to be highly effective treatments for adult onset PTSD or other psychological conditions.*

A study by van der Kolk et al compared EMDR, Fluoxetine and placebo for adult and child onset PTSD. The finding was that while both EMDR and Fluoxetine had similar short term effects on symptom reduction, EMDR showed prolonged and improving results and was the most effective treatment at six month follow-up. The results were very different, however, for those who had experienced adult onset trauma as opposed to child onset trauma. At the six month follow up, 75% of adult onset PTSD sufferers receiving EMDR were asymptomatic while only 33% of those with child onset PTSD were asymptomatic.<sup>xxii</sup> This finding is beginning to be replicated in other studies with reference to other interventions.

Consideration of studies which compare the *patient-reported* symptoms of trauma as a result of different interventions is also important. Van De Kolk compares the results of CBT and EMDR with specific reference to patient-reported trauma symptoms.<sup>xxiii</sup> Two further studies use the same rating scale of symptoms to compare CBT and EMDR, and find that EMDR achieved a greater reduction in trauma symptoms with a slightly shorter treatment cycle than CBT. Once again it is important to note that adult onset PTSD seems to resolve more quickly.<sup>xxiv</sup>

It seems that considerably more study is needed to reach conclusions about the type of treatment particular to complex trauma clients. In fact there are considerable problems with the way in which results are currently reported. Van de Kolk explores the difficulty of comparing non-CBT clinical studies to studies which use CBT.<sup>xxv</sup> CBT studies tend to be bigger and better funded. The generally much greater sample size of CBT studies means that the latter can achieve 'significant results' with a smaller clinical treatment effect than smaller, less well-funded studies of other treatments. Van der Kolk suggests that the most clinically important factor is *symptom reduction*, and it is significant that *according to this criteria, smaller studies are actually showing greater symptom reduction with some alternative (i.e. non –CBT) interventions.*

Another study explores the complexity of trauma treatments in detail, including the difficulty of comparing different types of interventions when studies are of vastly different sizes. Meta-analysis can lack transparency and some meta-analyses and reviews use non-contemporary treatment methods.<sup>xxvi</sup>

*Substantial clinical opinion, from among the world's leading complex trauma therapists, is that in order for trauma to be effectively resolved purely cognitive interventions are insufficient.* This is based on the fact that trauma *disrupts physiological functioning.* Whether it is pre-verbal or non-verbal, trauma can affect the brain in such a way that trauma memories are not verbally or cognitively encoded. This mandates the need for a 'bottom up' approach which includes:

- sensorimotor work (eg Fisher and Ogden in Courtois and Ford (Eds) *Treating Complex Traumatic Stress Disorder*<sup>xxvii</sup>; plus many other studies);
- EMDR (many studies);
- Alternative therapies such as trauma informed yoga (shown to be effective in mood regulation in 'treatment resistant' survivors of complex trauma)<sup>xxviii</sup>

As a trauma-informed principle it is important to consider *what clients say worked for them.*<sup>xxix</sup> We need to look at how we engage clients who are inappropriately labelled 'treatment resistant', and who do not like or want cognitive and exposure work. Such clients are likely to need longer term intervention, and to have tried and 'failed' at both cognitive and exposure-based work.

*It is essential to meet the challenge of treating those who will not, cannot, or don't want to do CBT or exposure-based work. Thus it is critical to be aware that evidence-based alternatives are now available and endorsed by experts in the field.*

It is well recognised clinically that early and sustained abuse, particularly sexual abuse, is likely to result in disorders of the personality and dissociative disorders. This means that effective treatment of these disorders needs sustained consideration. These complex conditions require intensive and long term therapy. We know, however, that recovery is possible and that treatment is highly cost-effective, not

only ethically but economically. While much more research into the treatment of these disorders is needed, there is evidence to suggest they respond better to psycho-dynamically orientated therapy than to CBT.<sup>xxx</sup>

Treatment of complex dissociative disorder requires highly specialised and long term interventions. Many of these are well articulated by some of the leading thinkers, researchers and practitioners of the complex trauma field and these learnings need to inform our treatment responses.

Pertinent texts include:

- Van Der Kolk (2014) *The Body Keeps the Score: Mind, brain and body in the Transformation of Trauma*
- Boon, Steele and Van Der Hart (2011) *Coping with Trauma-related Dissociation*
- Chu (2011) *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders*
- Van der Hart, Nijenhuis and Steele (2006) *The Haunted Self*

### 3. What helps or facilitates access so victims and survivors receive what they need?

For victims and survivors to be able to receive what they need, the right services need to be available, affordable and accessible for as long as they are required at any particular time in the life cycle. Information regarding what services are available, how to access them, and how to know that particular services are appropriate to their needs must be available for survivors, family members and service providers/practitioners. Only in this way can people make an informed choice with ready access to services which will facilitate pathways to recovery.

#### Recommendation 6:

*Survivors of childhood trauma and sexual abuse need access to ongoing, affordable services which are trauma-informed and which offer appropriate support at any period during the life-cycle.*

#### Recommendation 7:

*Referral pathways need to be streamlined (so that there is 'no wrong door'); psycho-education needs to be readily available, and all service-providers (i.e. not just clinical staff but personnel of all advocacy, support and other services) need to be fully conversant with ways of operating which reduce the potential for overwhelm and re-traumatisation.*

Mechanisms need to be established both within and across services to ensure consistency and coherence of a trauma informed approach and the appropriate qualifications and respective skill-bases of all staff/practitioners.

#### Recommendation 8:

*ASCA recommends the establishment of a centralised agency to oversee and coordinate the introduction of minimum standards and the necessary intersectoral links, and with which various stakeholders would register (even as the range of services involved would operate according to their more specific and particular needs). This agency could facilitate research, collaboration and referral pathways.*

A centralised agency could facilitate collaborative practices and referral pathways, and share information on research and workforce training. It could also provide a valuable resource for data collection, and to conduct longitudinal studies and outcome measurement. Such a database could be made available to professionals and consumers and across all sectors, including those working with survivors of CSA.

Consideration should be given to the appointment of trauma ‘champions’ within organisations (Jennings, 2004; Falloot & Harris, 2009) who would both actively assist implementation of trauma-informed practice within their organisations and liaise with the wider coordinating body.

If services and treatment do not operate according to trauma-informed principles their uptake and effectiveness will be limited even if services are available and seemingly accessible. If and when survivors can be confident that the spectrum of available services is comprehensively trauma-informed (i.e. irrespective of the many differences between services which will legitimately remain considerable) they are much more likely to engage with the relevant services to receive the support they need.

**What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?**

At least in the short to medium term, there are and will remain various barriers to survivors gaining the institutional support and treatment they require.

The National Standards of Practice Manual: for services against sexual violence (NASASV, 1998) state as a principle that, “Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community.”<sup>xxxii</sup>

*The most effective measure to erosion of such barriers is introduction of the mandate that all current (and future) services should become trauma-informed.*

**Recommendation 9:**

***The introduction of trauma-informed practice is made mandatory within all current and future services to which adult survivors present, and barriers and structural disadvantages currently experienced are identified and addressed.***

Basic training in trauma-informed practice for service-providers (i.e. as well as specialised training for clinicians) is now readily available, highly cost effective, and can be readily rolled out as are the mechanisms to embed such practice within and across institutions and systems of care.

The following discussion looks at different service provider groupings.

## 1. Primary care services

To establish the nature of the barriers we need to look at the structure of the current system. The reality is that large numbers of people first access support from their primary care practitioner. ASCA recommends the active engagement, education and training of practitioners within the Australian primary care system. A unique opportunity exists to educate and up-skill GPs and practice nurses within Primary Health Networks as a first port of call.

Strong longitudinal and epidemiological data<sup>2</sup> exists which suggests that on a daily basis and often unknowingly, primary care practitioners see a number of patients experiencing the cumulative effects of child abuse and trauma (*'[r]elationships of this magnitude are rare in epidemiology'*<sup>3</sup>). *Within primary care settings across Australia, the prevalence of trauma and its many effects largely go unrecognised, unacknowledged, misdiagnosed, and unaddressed.*

As Bloom and Farragher<sup>4</sup> underline, not only is trauma not screened *for*, it is actively screened *out*. *This is a costly anomaly which requires urgent rectification.* Diverse presentations, high comorbidity, and/or unspecified pain (i.e. 'medically unexplained symptoms'; MUS) mean that patients receive discrete diagnoses based on *presenting symptoms*, while the *underlying trauma* remains unrecognised and thus untreated.

Neither undergraduate courses nor postgraduate professional development programs focus on addressing the public health challenge trauma represents.

Failure to entertain the possibility of underlying trauma in a high proportion of patients who present to primary care settings, - and lack of understanding of the public health challenge this represents - means that practitioners will remain unable to respond in an informed manner at the vital first contact point of client need.

### Recommendation 10: 'No wrong door'

*Education and trauma-sensitive training of primary care practitioners across Australia should be prioritised to facilitate survivors receiving appropriate support. Such support may be direct or via targeted referral (including specialist counselling/therapy from an accredited and/or appropriately qualified practitioner).*

<sup>2</sup> Felitti VJ, Anda RF, Nordenberg D, et al (1998) 'The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction', *American Journal of Preventive Medicine*, 14, 245-258. ; Shonkoff, J. P., Garner, A.S. et al. (2012). "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *American Academy of Pediatrics*, 129(1): e232-e246.

<sup>3</sup> Felitti, V.F. & Anda, R.E.; 'The Relationship of Adverse Childhood Experiences to adult medical disease, psychiatric disorders and sexual behaviour: implications for healthcare', in Lanius, R.A., Vermetton, E. & Pain, C., ed. *The Impact of Early Life Trauma on Health and Disease* (2010) Cambridge University Press, p.82.

<sup>4</sup> Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. New York: Oxford University Press, p.224.

- **Trauma screening**

***‘If ever there were a need for true primary prevention, this is the area’.*<sup>5</sup>**

A major recommendation related to primary care settings, as well as non-specialist services, is the *introduction of trauma screening*. The ACE Study<sup>6</sup> provides the evidence base for the benefits of trauma screening. As part of the study, 440,000 people undergoing routine comprehensive medical evaluation completed a questionnaire which included questions related to prior trauma. The data from 100,000 people who responded to the questionnaires over a 2 year period was then analysed. This questionnaire was completed at home and then either presented to or analysed for review by their primary care physicians.

The data showed an extraordinary 35% reduction in visits to doctors’ surgeries the following year (as compared to year prior), 11 % reduction in visits to emergency departments and 3 % reduction in hospitalisations (resulting in enormous cost savings for this single year alone). Comprehensive implementation of trauma screening would constitute a profound and substantial outcome in terms of health service utilisation.<sup>xxxii</sup>

*‘We have demonstrated in our practice that this approach [i.e. carefully designed questionnaires ...] is acceptable to patients, affordable & beneficial in multiple ways’<sup>7</sup>.*

The development of a trauma screening tool for use within the Australian primary care system would build on overseas evidence which has established the applicability, multiple benefits and cost-savings of this approach. Education and training targeted to practitioner groups and focussed on the policy and practice requisites of trauma informed services should also be prioritised to establish trauma informed service responses within primary care settings across Australia.

In the ACE Study the introduction of the questionnaire was coupled with ‘trauma sensitive’ training for primary care physicians in how to respond appropriately and in a trauma-informed way to affirmative responses made during the screening process.

Considerable economic - as well as emotional, physical, relational and other - savings would result from the implementation of basic trauma screening in the context of visits to the GP (often the first and primary contact point for survivors experiencing complex trauma-related health issues). Introduction of universal trauma screening in primary care settings would be of particular benefit to the cohort of survivors who are ambivalent about accessing counselling and ‘psychological’ support, but who feel less unease about regular visits to the GP.

---

<sup>5</sup> Felitti, V.J. (2011) ‘The Adverse Childhood Experiences Study: How Maltreatment in Childhood Can Lead to Chronic Disease in Adulthood’, Transcript of teleseminar with Ruth Buczynski, PhD, The National Institute for the Clinical Application of Behavioral Medicine, nicabm. [www.nicabm.com](http://www.nicabm.com) p.18.

<sup>6</sup> [www.ACEStudy.org](http://www.ACEStudy.org)

<sup>7</sup> Felitti VJ, Anda RF; The Relationship of Adverse Childhood Experiences to Adult Health, Well-being, Social Function, and Healthcare : Lanius/Vermetten/Pain Cambridge University Press, 2010



**Recommendation 11:**

*Universal trauma screening which is aligned to preventative health screening should be developed and implemented throughout the Australian primary care system.*

**2. Mainstream services**

Survivors of institutional child sexual abuse access services from a diversity of public and private practitioners and services, as well as a range of community managed organisations. This includes but is not limited to: primary care, health and mental health services; drug and alcohol services; family support services, community health, settlement services, aged care, youth services, child protection services, domestic violence services, supported accommodation; disability services; legal and justice services; employment services; men and women's health services; counselling, psychotherapy, psychology, social work, psychiatry, nursing and mental health nursing and occupational therapy.

Effective services for adult survivors should be increased in number, geographical spread and diversity, but should also operate according to the principles of trauma-informed practice. Current research suggests that 'creating a trauma-informed culture in and of itself could help staff and clients make better recoveries than has previously been possible'.<sup>8</sup>

**Recommendation 12:**

*Trauma-informed practice is the gold standard and orienting principle within all mainstream services irrespective of their structure and form of support and therapeutic services provided to survivors.*

The importance of psychological services to survivors being offered from within the framework of trauma-informed practice (i.e. regardless of all other variations which may exist both between services and across the service sector as a whole) cannot be overstated. It is also the foundational and organisational benchmark ('gold standard') which should orient all consideration of this topic and the criteria according to which the viability of all effective delivery models should be assessed.

This point needs to be consistently emphasised and reiterated. This is because like all formulations and slogans 'trauma-informed' practice can be referenced and gestured towards in the absence of appreciation and implementation of what it actually entails. To the extent that trauma is not yet a public

<sup>8</sup> Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary* (New York: Oxford University Press, 2011), p.15.

health priority – even as one face of it; i.e. PTSD, is increasingly acknowledged both within the mental health system and the wider public domain – circulation of the concept is no guarantee that its translation to practice is proceeding concurrently. Indeed there is a risk of the opposite occurring, and that reference to ‘trauma-informed’ practice may become a mantra and ‘tick box’ which is assumed to be in place when the comprehensive restructuring it requires at all levels does not proceed at all.

Vast numbers of people who access diverse services experience the effects of complex trauma.<sup>9</sup> Thus it is imperative that the workers with whom they engage - *including in supportive and non-clinical roles* - are aware of the effects of trauma on the brain and body. Accordingly they will be able to engage in ways which reduce the likelihood of re-traumatisation, and should receive supervision which can assist them in so doing. *“Trauma-informed services are designed specifically to avoid re-traumatising those who come seeking assistance...”*<sup>10</sup>

Combining trauma-informed oversight of employee performance with active support to help staff discharge their roles is challenging. However *it is essential for client outcomes and professional organisational practice, as well as to safeguard against staff burn-out and occupational stress*. Many organisations and agencies lack support for client services and for staff who work with complex trauma clients.<sup>11</sup> This urgently needs to be redressed, because research shows that absence of such support *at any level* puts both clients *and* staff at risk.<sup>12</sup>

One of the many benefits of trauma-informed practice is a decrease of the risks of vicarious traumatisation for service personnel. As well as improving client-staff interactions, sensitivity to trauma in others has the positive effect of enhancing the well-being of staff. Thus introduction of trauma-informed practice benefits all parties (*‘a program cannot be safe for clients unless it is simultaneously safe for staff and administrators’*<sup>13</sup>). Re-traumatising practices within systems, services and institutions can be minimised by embedding trauma-informed practice within policies, procedures, cultures and all practices.

### **Recommendation 13:**

***Integrated training programs for staff and practitioners around trauma-informed practice and vicarious trauma which include mechanisms for ongoing quality assurance need to be mandated.***

*Benefits can also be achieved by minimising re-traumatising practices within institutions, organisations and agencies accessed by people who experience the impacts of childhood trauma (see the second set of ASCA Guidelines as above). Essentially, trauma-informed practice seeks to create environments and*

<sup>9</sup> van der Kolk, *ibid*; Jennings *ibid*.

<sup>10</sup> Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care (CTIC): A Self-Assessment and Planning Protocol’ (2009), p.2.

<sup>11</sup> Laurie Ann Pearlman & James Caringi, ‘Living and Working Self-Reflectively to Address Vicarious Trauma’, in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, 212-213.

<sup>12</sup> *Ibid*, p.214.

<sup>13</sup> Bloom, S. L. (2006) ‘Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation’. Alexandria, VA: National Technical Assistance Centre. , p.2.

*management practices that do no harm and which do not replicate the sorts of environments which facilitate and conceal childhood abuse.*

### **Trauma-informed service delivery can reap significant benefits across a range of indicators.**

These include:

- \* improved staff-client relations
- \* enhanced OHS
- \* risk management

The latter benefits of comprehensive introduction of trauma informed practice are not well known and urgently need to be. Widespread understanding of the extent to which *trauma informed practice benefits not only for clients but also for service providers, personnel and the general public* needs to be consistently promoted.

Clinical and neuroscientific research shows that the positive relational experiences which assist realignment of disrupted neural pathways (i.e. the hallmark of trauma) *also facilitate well-being in the absence of trauma* - a 'win-win' situation.<sup>14</sup>

This means that introduction of trauma-informed practice across and within services also helps to minimise the likelihood of staff alienation, disengagement and burn-out, and the significant financial as well as psychological and physical costs with which they are associated.

Compliance costs for implementation of trauma-informed practice would be offset through savings related to reduction of the costs of ill-health and its escalation. Absenteeism and compensation claims would likewise yield to the benefits of enhanced work motivation.

### **3) Specialist services**

The service needs of adult survivors have been perennially overlooked. This is notwithstanding the existence of a small number of organisations around Australia which provide counselling support for childhood sexual abuse survivors. While the situation has improved somewhat as a result of investment related to the work of the Royal Commission, building specialist expertise is not a short-term proposition. The scale of the service gaps is substantial and long-standing, and far more needs to be done.

While specialist sexual assault services provide expertise and experience, they are unable to meet demand. In many cases survivors experience long waiting periods before the service can be accessed. Prioritisation of recent sexual assaults over historical abuse and trauma (the corollary of core funding prerogatives) means that crisis-care - including forensic care - and short-term counselling models take precedence over other needs which present as less urgent.

---

<sup>14</sup> Doidge, N. (2007) *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science* New York: Viking; Siegel, D.J (2009) *Mindsight*. New York: Random House.

The need for specialist agencies cannot be overstated. There are also particular survivor cohorts in urgent need of specialist support. Despite the provision of some specialist services, Forgotten Australians, Child Migrants, Aboriginal and Torres Strait Islander peoples, survivors from CALD (culturally and linguistically diverse), survivors with a disability, male survivors and survivors from LGBTI communities similarly struggle to access the particular care they require. Expansion of existing specialist services and further investment in trauma-informed services for them and other unique groups (i.e. as well as for survivors more generally), is much needed.

Separate agencies dedicated to addressing particular needs are vital for many survivors to feel safe. A 'safe' place is an environment that reduces the likelihood of 'triggers' to traumatic memories and responses.<sup>15</sup> Just as specialist services exist for particular groups as outlined above, so too unique specialist services for adult survivors of childhood trauma and abuse – i.e. services with which survivors can identify, trust and feel safe - are crucial.

#### **Recommendation 14:**

*Survivors, survivor groups and specialist services which are centres of excellence for supporting adult survivors are best positioned to spearhead policy and practice initiatives. Active investment is needed to support a coordinated comprehensive model of care including continued and increased availability through effective phone lines and online services.*

Timely, active, and comprehensive intervention requires, among other things, appropriate support, counselling, resources and services to promote recovery.

When survivors work through their childhood trauma they are freed to live productive, healthy and constructive lives, as are their children.<sup>16</sup> A full spectrum of services and resources needs to be available to assist the process of trauma resolution and healing.

#### **Recommendation 15:**

*All practitioners supporting or providing therapeutic treatment to survivors must be specifically trained to deal with the complexity of the issues involved. Such services need to be accessible and affordable throughout Australia. Widespread investment in training supported by a program to accredit practitioners of a range of disciplines is also recommended - appropriate training and regulation of practitioners is critical.*

<sup>15</sup> ACSSA . (2005). ACSSA talks to Sandra Basham of the Incest Survivor's Association. Australia: ACSSA Newsletter (8) June 2005.

<sup>16</sup> Siegel, 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Solomon & Siegel, ed. (2003) *Healing Trauma*. New York: Norton, 1-56.

**The services of many private practitioners** (psychotherapists, counsellors, psychologists and others) are not subsidized under the Medicare Better Access program and when they are, they are generally limited to 10 sessions per calendar year. This means that many clients who consult practitioners are unable to receive fee remuneration which effectively precludes large numbers of trauma survivors from psychological treatment and support they would otherwise receive. The restrictiveness of the Medicare Better Access scheme – both in terms of the occupation of practitioners whose services are subsidized and the modalities which are endorsed – and the need for reform in both these respects has been powerfully articulated elsewhere (King, 2013).

---

#### **4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors?**

Survivors of child sexual abuse and trauma need, but currently do not receive, services which are affordable, accessible, and fully trauma-informed. This applies to therapeutic treatment services (staffed by specialist clinicians with the requisite skills to work with complex trauma) advocacy and support services, and the variety of other services (e.g. employment, legal) with which survivors come into contact.

Few services for provision of psychological support adequate to meet the recovery needs of adult survivors of child sexual abuse exist and there are many service gaps in this area. Mainstream services which attempt to cater to this large cohort (which represents a high proportion of the overall number of people who present for psychological care) are not well-equipped to do so.

While sexual assault, drug and alcohol and other services address some of this need, there is a paucity of dedicated specialist services for adult survivors. Despite research establishing that recovery for people with unresolved trauma (and interception of its effects into the next generation) is possible, Australians who have experienced childhood trauma often struggle to get their needs met. They typically present to multiple services over a long period of time and receive care which is fragmented, poorly coordinated and often uninformed. They also find it hard to access follow-up services due to poorly coordinated referral pathways.

The result is a 'merry go round' of unintegrated care in which people are often re-traumatized. The effects of trauma, past and current coping strategies, acquired risk factors, and the many conditions and challenges related to their prior trauma are not identified or addressed.

Commonly, without access to the right services, the symptoms of people who experience complex childhood trauma get worse. Their health deteriorates - both in the short and longer term - while practitioners struggle to establish what the issues are and what to do. Needless to say this is costly at all levels: individual - psychological, physical and social as well as financial and systemic.<sup>17</sup>

---

<sup>17</sup> Adults Surviving Child Abuse 2012 Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery Adults Surviving Child Abuse: Authors Kezelman C.A. & Stavropoulos P.A. Executive Summary

*'Both women and men with histories of trauma are commonly misdiagnosed and retraumatized by wrongful treatment...Such maltreatment exacerbates their condition and perpetuates their need for costly emergency, acute and long term mental health services...This misuse of taxpayers' money and perpetuation of human tragedy must no longer be allowed to continue'.<sup>18</sup>*

## **How could these services be shaped so they better respond to secondary victims?**

In order to provide services that meet the complex needs of this client group, it is imperative that practice is underpinned by a professional workforce, which is experienced, skilled and knowledgeable about the impacts of child sexual abuse.<sup>19</sup>

The 2002, Women's Health Statewide, South Australia research project: *It's Still Not My Shame* explored the current service needs of adults who had experienced child sexual abuse. The report findings (Holden 2002: 21) highlighted the issues and needs for adult survivors and workers as follows:

- *'The demand for counselling and group services by adult survivors continues to be high, with many services in the government and non-government sector reporting they are unable to respond to a large number of requests for services.*
- *There is a lack of a coordinated approach to issues of childhood sexual abuse for adult survivors in relation to service provision, training and policy issues.*
- *Limited training opportunities exist for workers in this area, including basic and advanced childhood sexual abuse training.*
- *There is no specialist after hours' crisis service.<sup>20</sup>*

Holden<sup>21</sup> notes that without such an agency there remains a continuing lack of coordination around service delivery, training and community education. This absence of oversight results in:

- *'Limited identification of the health cost associated with poor coordination between services dealing with childhood sexual abuse, mental health and other related issues such as domestic violence.*
- *The needs of adult survivors of childhood sexual abuse not being reflected in policy development, organisational strategic planning and subsequent service delivery.*
- *Limited encouragement of research and community education strategies, including prevention.*

---

<sup>18</sup> <http://www.theannainstitute.org/a-bio.html>

<sup>19</sup> Mental Health Coordinating Council 'Reframing Responses' Literature Review August 2006

<sup>20</sup> Holden, T. (2002), *It's still not my shame: Adult survivors of childhood sexual abuse report*, Women's Health Statewide, Women and Children's Hospital, Adelaide, and online at [http://www.whs.sa.gov.au/pub/Its\\_still\\_not\\_my\\_shame\\_report.pdf](http://www.whs.sa.gov.au/pub/Its_still_not_my_shame_report.pdf)

<sup>21</sup> *Ibid* (2002:22)

- *Inadequate development of comprehensive training for allied health workers and limited opportunities to warehouse appropriate literature or amass a body of knowledge or expertise for workers to access.*
- *Lack of a systematic approach to informing health planners and purchasers of services about current service trends and issues for adult survivors of childhood sexual abuse.*<sup>122</sup>

At the Home Truths Conference (2005) long term workers in the field said that *under-resourcing had become so widespread and had existed for so long that it was becoming normalised.*<sup>23</sup> Given the enormous costs of unresolved childhood trauma at all levels (i.e. for the whole of society as well as for the many individuals directly affected; see above) we reiterate the warning of US pioneer and advocate Ann Jennings that *'[t]his misuse of taxpayers' money and perpetuation of human tragedy must no longer be allowed to continue.'*<sup>24</sup> **It is affirming to consider the ways in which introduction of a national redress scheme might comprise a major instrument of remedial action in this regard.**

Child sexual abuse survivors frequently have no subsidised access to counselling. Services often prioritise 'recent assaults' and crisis intervention, and cannot meet the demand.<sup>25</sup> Survivors also consistently highlight a range of inadequacies in current service provision. These include difficulties in finding: expert, long term, affordable counselling; a lack of support groups and workshops; services that only offer a few sessions or telephone counselling; insensitivity and/or ignorance within generalist health services, and inadequate training and responses from a wide spectrum of specialist services, including drug and alcohol and mental health services.<sup>26</sup>

In light of the unique understanding afforded by lived experience, the need for a 'consumer voice' (which now informs mental health service delivery) is also pertinent. Survivor contribution to service delivery planning, education and training, evaluation and involvement in improving quality outcomes and promoting access and equity<sup>27</sup> is a trauma informed principle: *'professionals and institutions should not underestimate the patient's ability to be very useful and active in their own treatment'*.<sup>28</sup>

The AIFS<sup>29</sup> in its August 2013 CFCA paper agrees that a comprehensive service system for adult survivors of child sexual abuse needs to involve both specialist and non-specialist service sectors.

---

<sup>22</sup> Holden, T. (2002), *It's still not my shame: Adult survivors of childhood sexual abuse report*, Women's Health Statewide, Women and Children's Hospital, Adelaide, and online at [http://www.whs.sa.gov.au/pub/Its\\_still\\_not\\_my\\_shame\\_report.pdf](http://www.whs.sa.gov.au/pub/Its_still_not_my_shame_report.pdf)

<sup>23</sup> Keel, M., Fergus, L. & Heenan, M. (2005). *Home Truths: A Conference in Review*. ACSSA Issues (3) March 2005.

<sup>24</sup> <http://www.theannainstitute.org/a-bio.html>

<sup>24</sup> *ibid*

<sup>25</sup> *ibid*

<sup>26</sup> WISN. (1996). *A Submission to the Royal Commission into NSW Police Service Paedophile Segment*. The Women Incest Survivors Network Inc.

<sup>27</sup> Mental Health Coordinating Council 'Reframing Responses' Literature Review August 2006

<sup>28</sup> Foreword by Stillwell, *ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, p.viii.

<sup>29</sup> Child sexual abuse: Summary of adult survivors' therapeutic needs 26 August 2013 AIFS CFCA

It defined the elements of specialist services as follows:

Specialist services (i.e. those that directly address the specific traumatic effects of CSA) should:

- *Be grounded in a sound understanding of child sexual abuse.*
- *Be transparent about the conceptual framework on which the interventions are based.*
- *Demonstrate the specific effects of trauma targeted by the service.*
- *Demonstrate how the intervention addresses the context of sexual abuse.*
- *Demonstrate how the effectiveness of services/specific programs are evaluated.*
- *Engage highly skilled, specialist practitioners who have access to, and are encouraged to engage in, continuing professional development.*
- *Respond to the immediate needs of child sexual abuse survivors.*
- *Be supported to provide longer-term therapeutic interventions for adult survivors.*
- *Demonstrate cultural competency in understanding the impacts of CSA for Indigenous and CALD survivors.*

In common with ASCA, it also made the point that: “**Non-specialist or generalist services can be re-traumatising if they are unaware of CSA and its effects**”. To avoid this clearly unacceptable risk, non-specialist services should:

- *Provide basic education to all staff about the traumatic impacts of sexual abuse and other interpersonal violence.*
- *Provide clinical training to direct care staff on impacts of trauma and relationship to unusual or difficult behaviours.*
- *Undertake appropriate screening for signs of trauma.*
- *Establish procedures to avoid re-traumatisation and reduce impacts of trauma.<sup>30</sup>*

ASCA’s daily interactions with survivors reflect the realities of survivor experiences in a system in which specialist and non-specialist services are not adequately trained to meet their needs and/or to minimise the risks of re-traumatisation:

*‘Every day ASCA receives calls from child abuse survivors who feel they have been failed by the system and don’t know where to turn... Every day consumers call recounting how they have been let down by one arm of the health system or another, by an agency, a worker or a practitioner. By a GP who was uninformed, who didn’t inquire about trauma, despite symptoms which were highly suggestive. By a worker who didn’t know how to respond to a disclosure, a counsellor, psychologist or psychiatrist they felt had*

---

<sup>30</sup> Child sexual abuse: Summary of adult survivors’ therapeutic needs 26 August 2013 AIFS CFCA



*minimized or dismissed their feelings and experiences rather than listening empathically and validating them'*<sup>31</sup>

### **Recommendation 16:**

*The need for specialist services informed by survivor experience, and which combine clinical, research and academic expertise, and which are dedicated solely to the needs of adult survivors, cannot be overstated.*

Meeting the unique diverse and complex needs of adult survivors requires consistent and committed focus. ASCA is one of the very few specialist Australian services dedicated to the advocacy, support and therapeutic treatment needs of adult survivors of childhood trauma in all its forms.

Many services attempt to cater to the needs of secondary victims and supporters of child sexual abuse. The reality, however, is that few have the funds – and often the relevant skills – to do so effectively.

As these cohorts – and society more widely – learn to operate in a trauma-informed manner the benefits to all groups and in all respects will be enormous. Investment in the relevant workshops, online resources etc. will assist promotion of the attitudinal and practical shifts which need to occur to ensure these outcomes.

### **Recommendation 17:**

*Trauma-informed practice needs to be embedded within and across services in all services and at all levels of operation for the benefit of family and friends as well as `secondary victims' more broadly.*

## **Accreditation and Training**

Survivors of institutional child sexual abuse seeking to access psychological support benefit from contact with diverse health professionals and present to a wide range of services and practitioners.

No single occupation or skill base has a monopoly on ability to serve survivors- *there is clear evidence that psychological interventions can be effectively provided by a wide range of health professionals, including nurses, and by appropriately trained non-professionals'*<sup>32</sup>.

<sup>31</sup> Dr Cathy Kezelman <http://cathykezelman.com/trauma-informed-care/359/>

<sup>32</sup> King, R. (2013) 'Psychological services under Medicare: Broken but not beyond repair'. *Psychotherapy in Australia* (Vol.19, No.2), p.41 (emphasis added).

**Recommendation 18:**

*Workforce development which includes ongoing quality assurance is needed for diverse staff and support workers, clinical and non-clinical.*

**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?**

Advocacy, support and therapeutic treatment services must respect each survivor's cultural context including their race, ethnicity and language. They must also take into account factors such as age, gender, sexuality and intellectual and physical ability and respond appropriately to each individual's life circumstance.

Existing services for diverse survivor groups are piecemeal, and often lack the time and resources required to meet disparate needs and for adequate outreach. Even when services offer quality programs many of them are sorely stretched in terms of capacity and reach and insufficiently funded to support effective planning and sustained quality assurance. This is true of support and advocacy services as well as therapeutic treatment services.

Even when services exist, marginalised groups, especially Aboriginal and Torres Strait Islander peoples, those from CALD communities, survivors with disabilities as well as those living in rural or remote areas, are often unaware of what services are available.

**Recommendation 19:**

*A service system which recognises and addresses diversity including ethnicity, race, language, place, age, sexuality, gender, intellectual and physical ability as well as geography is needed. It is important for all service options to be communicated to those seeking support and therapeutic treatment services.*

**Recommendation 20:**

*Funding for the requisite service system to meet the needs of all survivors including those from diverse groups is commensurate with complex, diverse, sustained and ongoing needs.*

## What types of models and approaches are used to address the particular needs of these populations?

The National Standards of Practice Manual from the National Association of Services against Sexual Violence (NASAV), published in 1998, applies access, equity and human rights' principles which remain pertinent to inform standards and guidelines for the delivery of ethical and sensitive services for survivors:

- *The Service against sexual violence works to ensure the accessibility and appropriateness of its service delivery to all those victim/survivors in its community, whether they are women, children or men.*
- *Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community.*
- *Equity implies the fair treatment of all service users, a just allocation of resources and positive discrimination towards those facing additional barriers to services.*
- *Service provision respects the cultural context of victim/survivors such as their race, ethnicity and language, and factors such as geographical location, socio-economic background, gender, age, sexuality and level of ability.*<sup>xxxiii</sup>

Attunement to diversity is a core principle of trauma-informed practice and attentiveness to the more particular needs of specific cohorts is necessary within and across services (also see response to pt 3 below). Application of trauma-informed principles may vary according to context and client/cohort specificity.

For example when offering choice (a foundational principle of trauma-informed practice) to survivors, what this actually entails needs to be tailored. Survivors may initially have limited capacity to respond to the possibility of choice. This is due both to prior lack of provision of options (where their needs and preferences were not taken into account) and the perceptual rigidity which can be a legacy of complex trauma. For survivors of diverse cultural backgrounds, and in light of variables such as gender, age, and ethnicity (each of which is shaped by diverse cultural 'norms') the notion of choice may also differ from the sense in which it is understood by service-providers in western societies.

Similarly, while *collaboration* is likewise a core principle of trauma-informed practice, clients with a history of complex childhood trauma frequently '*ha[ve] no clear template for collaboration*'.<sup>33</sup> This is a possible legacy that non trauma-informed therapists often fail to appreciate. Knowledge of the neurobiological impacts of complex trauma (which is foundational to trauma-informed practice) means that account needs to be taken of the challenges survivors may experience in processing positive values

---

<sup>33</sup> Gold, S.N. (2009) 'Contextual Therapy', in Courtois, C.A. & Ford, J. D., ed. Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide. New York: The Guilford Press, p.240.

and experiences. Depending on the point at which they access services and/or engage in counselling, positive experiences may be quite unfamiliar.

In this context, a helpful distinction has been drawn between the complex trauma client as expert in their own experience on the one hand, and as labouring under the effects of childhood trauma and/or abuse which entailed loss of key learning experiences in a range of domains (emotional, cognitive, behavioural) on the other.<sup>34</sup>

Choice should be embedded into all interactions with survivors (which can be done in a myriad of small, yet often disproportionately effective ways). But it needs to be done with high sensitivity, without expecting that choice will necessarily be processed and responded to. For this reason, the trauma-informed principle of respect for vulnerabilities and diverse coping mechanisms (which is consistent with such a strengths-based orientation) should be a guiding principle when introducing and offering choice/s to survivors.

NASASV (2002) recommended the following initiatives when supporting survivors of sexual violence which are grouped into nine major strategies:<sup>xxxiv</sup>

- *Outreach and community development projects*
- *Media, communication and educational strategies*
- *Developing access and equity strategies within sexual assault services, and designating an access and equity worker position*
- *Working with cultural consultants within service governance*
- *Employing Aboriginal workers*
- *Employing ethnic minority workers*
- *Collaborative projects*
- *Workers in Aboriginal specialist organisations*
- *Workers in Immigrant women's organisations*

While it is not possible to address the specificity of need of every group of survivors who have particular needs the following comments are made in relation to CALD and Aboriginal and Torres Strait Islander communities.

In *Cultural Diversity and Services Against Sexual Violence*, NASASV (2002) states that barriers to access in mainstream services are frequently due to, “*racism and ignorance about the cultural practices of others reflected and embedded in individual worker's practices, as well as systemic arrangements.*”

Culturally and linguistically diverse communities (CALD): This group has particular problems in accessing services related to language and culture. Those affected may also experience difficulty when they are from a small cultural group, and frequently fear loss of confidentiality if they see a worker from inside their own community. Lievore (2003) suggests, “reasons that women from non-English speaking backgrounds are unlikely to report are varied and include personal, cultural and religious, informational

---

<sup>34</sup> Gold, *ibid.*

and language and/or institutional and structural.”<sup>xxxv</sup> Such factors are also pertinent when considering access to support services, especially in rural areas.

Garrett (1992) acknowledges the challenges in supporting diverse cultural groups with requisite specialist knowledge and skills and makes the following recommendation: “*services need to employ language-specific mediators – either bilingual sexual abuse workers, interpreters or sessional bilingual welfare workers.*”

Aboriginal and Torres Strait Islander Communities (ATSI): Colonisation, forced removal of children and adults from family, culture and land, institutionalisation, marginalisation and generational social disadvantage form the backdrop to institutional child sexual abuse within Aboriginal and Torres Strait Islander populations.<sup>xxxvi</sup>

Services which work with Aboriginal and Torres Strait communities need to work in a way which is culturally competent as well as trauma-informed. Being trauma-informed is all about understanding context, including cultural context and the particular issues experienced by specific communities, including the impacts of collective trauma, intergenerational trauma on whole communities, which compounds that experienced by individuals. Services must also recognise and reflect the interdependency of the wellbeing of individuals, families and communities and culturally resonant healing pathways.

Wingard and Lester (2000) identify five factors which can make it less likely for those from Aboriginal and Torres Strait Islander backgrounds who have experienced abuse to engage with services:

- *Attitudes of non-Aboriginal workers and practices such as ‘prying’ into personal details; disrespectful language; not seeking permission before taking action and not ensuring that people understood what was being proposed before proceeding*
- *Attitudes of other people using the services towards ATSI clients*
- *Absence of ATSI staff*
- *Alienating physical layout of service*
- *Organisation practices, such as: lack of flexibility, length of time allocated and lack of home visiting practices.*<sup>xxxvii</sup>

## **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?**

Survivors from diverse backgrounds and from specific cohorts face particular challenges in accessing and receiving appropriate assistance. Appropriate treatment of/contact with survivors which is culturally sensitive and attuned to markers of diversity will be best achieved when all such markers (e.g. gender, ethnicity, SES, age, sexual orientation, disability) are approached via the paradigm of trauma-informed practice.

The diversity of survivors applies both to groups and to individuals within specific cohorts. Thus effective services for CALD, ATSI, LGBTI clients and Forgotten Australians (to cite examples of group diversity) should be tailored to the specific needs of the particular group as well as to the individuals who comprise it. While increasingly emphasising the relational context in which personality is formed and functions, western psychotherapeutic modalities have been predicated on individualist models which have traditionally shown insufficient attentiveness to collective and group norms (Toporek et al, 2006).

Awareness of the possibility of unintentional bias should consistently be borne in mind, and steps undertaken to remediate this. Community support (i.e. where conducive to the recovery of the survivor) can and should be drawn upon where appropriate. To the extent that individual change may reverberate to different degrees within diverse communities, the drafting of 'impact statements' has also been proposed as one measure by which otherwise narrowly individualist interventions might be tailored and tempered (ibid)

Generalising and 'universalising' from western experience is a habitual and often unconscious attitude on which service-providers should be encouraged to reflect. Attentiveness to cultural – as all axes of – diversity is critical, as the applicability of 'western' norms cannot simply be assumed. Dominant and largely taken-for-granted 'norms' can reflect cultural and other forms of bias which may discriminate against 'non-norm' groups. In discussing the importance of cultural competence on the part of clinicians and service-providers, Brown (2009) elaborates the multiple forms of 'micro aggressions' from which members of dominant groups may be insulated but which comprise the backdrop or 'white noise' of everyday life for non-norm groups. These can comprise both an additional layer of trauma and a key source of trauma themselves.

*Secondary trauma can be experienced due to lack of cultural competence on the part of clinicians and service-providers* (Brown, 2009). Unintentional (i.e. as well as deliberate) discrimination can be enacted by service-providers along gender, ethnicity, sexual orientation, age, and other lines. Hence it is essential that the risks of unintentional bias are acknowledged and addressed, and that reflective practice which is also culturally competent becomes the new 'norm'.

*Trauma-informed practice and attunement to diversity in all its forms need to operate in tandem.*

While the latter is entailed by the former, both need to be explicitly addressed and adhered to at all levels of service operation. This is because the paradigm of trauma-informed practice is still relatively recent. Thus services which are currently attuned to diversity may at the same time be insufficiently trauma-aware.

### **Recommendation 21:**

***Coexistence of trauma-informed practice and attunement to diversity in all its forms must be a best-practice requirement of all services at all levels of operation if the needs of survivors of diverse backgrounds and contexts are to be effectively met.***

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

The need for incarcerated persons to receive appropriate support on and before their release back into society is an evolving area of focus in the literature on trauma-informed practice (*'As a powerful institution in society, law regularly encounters and deals with people, both as victims and offenders, whose lives have been shaped and harmed by traumatic events'*; Randall & Haskell, 2013: 523). People who have spent time in correctional facilities have specific needs in terms of reconnection with services which are aware of the nature of these specifics and able to tailor their programs accordingly. Such services potentially need to be 'wrap-around' in offering a spectrum of amenities – including social programs – to assist rehabilitation into the community because mainstream ties may be eroded or lost.

Concerted consultation with case-workers, parole officers and the plethora of personnel mandated to work with survivors prior and subsequent to their release from correctional facilities is necessary. Such personnel may be well equipped to identify and discuss implementable measures which can directly benefit this cohort in ways which its members may themselves be unable or unwilling to do. To the extent that society as a whole will benefit from successful transition of formerly incarcerated survivors to renewed membership of mainstream communities, such consultations and their practical follow-up should be accorded a priority area and funded appropriately.

---

## **Topic C: Geographic considerations**

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

The geographical distance and isolation of areas, including rural and remote, from urban and metropolitan regions raises particular challenges for appropriate servicing of survivors who reside in these areas. Compared to metropolitan regions, many sorts of services are less available and accessible in geographically isolated locations. This applies particularly to specialist complex trauma mental health services. When seeking therapeutic treatment, even when health professionals are accessible, survivors in non-metropolitan areas currently have no guarantee that the practitioners they consult possess the appropriate knowledge base and skill sets to address the multiple impacts of complex trauma.

This further underlines the importance of trauma-informed practice (i.e. for all services, clinical and non-clinical, specialist and non-specialist) to avoid inadvertent re-traumatisation. Affordability, accessibility

and absence of appropriately equipped services remain continuing challenges for survivors in non-metropolitan areas.

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

In a country as vast, yet as sparsely populated as Australia, adequate access to health services for regional, rural and remote residents is an ongoing challenge. This problem is heightened for mental health services, especially for specialist mental health services such as those needed to respond to complex trauma.

The health outcomes of rural Australians have traditionally been poorer than those of urban dwelling people. This seems to be partly to do with increased difficulty accessing health services, higher risk factors and the higher proportion of indigenous people living in rural areas compared to urban.<sup>xxxviii,xxxix</sup>

As regional, rural and remote Australians in general cannot access adequate mental health services their needs are often unmet or poorly met. In the area of complex trauma in which many people struggle to have their needs appropriately met, regardless of where they live, this failure is often compounded in rural and remote Australia.

Somewhat counter-intuitively, ASCA's 1300 phone counselling service is more likely to be accessed by regional, rural and remote Australians than the population distribution would indicate. Callers from these areas are over-represented in our statistics.<sup>3</sup>

ASCA consistently receives positive feedback about its service from regional, rural and remote callers which recognise not only the existence of the service but its quality in areas in which other services are lacking.

An example of recent feedback (May 2015) is from a female survivor, who lives 200 kilometres from a therapist. When she first began calling us almost 2 years ago she was very unwell and had very intrusive trauma symptoms. She calls between once weekly and once monthly depending on her symptoms. She is now much more stable, has stable housing and is able to use the grounding and stabilising techniques we have taught her. She has benefited enormously from psychoeducation about complex trauma and its impacts on her life, as this has normalised some of her symptoms, whereas in prior contacts with other services she has felt pathologised as "mad" or "bad". Although her community is unable to offer her therapy she has been able to re-engage with some community groups including a women's art group, which she finds helpful. In a recent call to the ASCA 1300 service she stated:

*"If it wasn't for you guys helping me over the last two years I would never have gotten as far as I have. I remember the day I saw that little blue flyer thing and I thought... 'these guys get it'. I picked up the phone and called and ever since then it's been much easier.... But I know I'm not finished yet, and I'm not going away just yet. I know I've still got some way to go on this journey, so sorry but you will be getting a few more calls from me!"*



A range of measures need to be implemented to assist survivors who are outside of metropolitan areas. These should be comprehensive in scope, and include forms of outreach which incorporate web based and call-in trauma-informed services. Resources, including of psychoeducation, mentoring and access to ongoing training for the relevant parties (i.e. re the broad array of relevant staff) will be essential.

The current situation – which is in urgent need of redress - is as follows:

- There are often no therapists within a viable travel distance;
- Many therapists lack experience and training in complex trauma;
- Costs of therapy, travel time and expense are commonly prohibitive;
- Suitable therapists or services are frequently booked out and unwilling to take new referrals;
- Services from agencies are often limited due to high demand and prioritisation of needs of victims of recent trauma over survivors. Survivors either can't access services at all or services are severely time-limited and inadequate in length for client need.

The combined effect of these impediments is that relying on face-to-face services for survivors who reside in non-metropolitan areas is a very limited option.

### Recommendation 22:

*Comprehensive web-based and call-in trauma-informed services need to be provided to survivors in regional and rural who are unable to access face-to-face services.*

---

## Topic D: Service system issues

**1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper.**

**Are these terms adequate and have they been defined appropriately?  
If not, what terminology and definitions should we consider using?**

The terms: 'advocacy and support' and 'therapeutic treatment' (i.e. as used in this paper) are appropriate and appropriately defined. Both terms do however encompass considerable diversity which risks being conflated in the absence of more specific detail as to the variety of services included. *Addition of the term 'trauma-informed' (i.e. when referencing both terms) is highly recommended.* This is both to distinguish services for survivors from the more generalist services currently available and to foster the transition to trauma-informed practice in and across all services with which survivors have contact.

Language is not only descriptive but also predisposing in that it serves to construct as well as reflect reality. To this extent, the terminology used to reference services for survivors performs a critical role in itself.

While such terminology will not necessarily be uniform and may legitimately differ, *all terminology which refers to services for survivors should be accompanied by reference to the need for all such services (i.e. regardless of their type) to be 'trauma-informed'.*

This is the major oversight of the terminology deployed in the Issues Paper, which is otherwise both comprehensive and impressive in its scope.

Ongoing need for insertion of the term 'trauma-informed' to all references to services for survivors (i.e. irrespective of their diversity and type) is not just a matter of semantics. It is crucial to *the discourse shift which needs to occur if the diverse range of services accessed by survivors is to effectively meet their needs.*

Frequent and consistent use of the term 'trauma informed' not only serves to normalise the concept (i.e. in the current context where it remains unfamiliar to many) but it also *actively assists the attitudinal shift which needs to occur for trauma-informed practice to be practically and comprehensively implemented.*

The term: 'trauma-informed' is not a single term among many, nor an optional extra. Rather, it is *the centre-piece of both the concept and practice needed for diverse services to meet the needs of survivors.*

---

## **2. Given the range of services victims and survivors might need and use, in 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?**

Responding appropriately to survivors requires specialist knowledge and understanding of trauma - its effects and dynamics, workforce education and training, and collaboration between survivors, family members, policy makers, and service providers. It involves changing assumptions about how we organise and provide services, build workforce capacity and supervise workers.

*‘Because abuse trauma may result in multiple vulnerabilities and affect many aspects of a survivor’s life, coordination across systems is essential. Integration of trauma, mental health and substance abuse is absolutely critical’<sup>xl</sup>.*

### **Recommendation 23:**

*Because abuse trauma can affect many aspects of a survivor’s life, coordination across systems is essential. Supporting survivors requires specialist knowledge and understanding of trauma - its effects and dynamics, workforce education and training, and collaboration between survivors, family members, policy makers, and service providers.*

The current service system is fragmented with disparate organisations delivering a range of services often in isolation, but unable to meet the complex needs of victims and survivors of daily functioning, mental and physical health and wellbeing.

Many survivors have experienced entrenched disadvantage related to their institutionalisation and compounded traumas. Thus they need diverse services as well as assistance in accessing and negotiating them. This includes but is not limited to *welfare, social services, housing, employment, legal, criminal justice, education, health, and mental health*. Historically service systems have worked in siloes with poor or inadequate communication between them. This leaves those seeking diverse services poorly supported and unable to access the care and support they need.

We are starting to see some collaboration across government and non-government services, cross-sector cooperation, partnership models and enhanced care coordination. However much more needs to be done to break down the boundaries between and across sectors and service systems, to develop a shared understanding of client need, and to coordinate ways of working which best meet those needs.

Service models which embed trauma-informed practice ‘bottom up’ as well as ‘top down’ represent the best means of ensuring practical and accessible support to survivors of child sexual abuse and trauma.

At a structural and policy level all aspects of service provision – formal and informal and from the first contact point – need to enshrine, reflect and consistently monitor the core trauma informed principles of *safety, trustworthiness, choice, collaboration and empowerment*. This system-wide change – which can be introduced incrementally and in a step-wise manner – will also be enacted relationally and interpersonally in enhanced modes of relating to survivors by diverse workforce personnel (e.g. respect for diverse coping mechanisms will become a standard requirement of practice akin to confidentiality, informed consent, respect for diverse backgrounds, etc). There will be a *shift from ‘caretaking’ to ‘collaborative’ ways of working, and movement from an illness/symptom-based model to one of skills acquisition* (‘strengths based’).

Unless and until the paradigm of trauma-informed practice is comprehensively introduced within the range of services with which survivors of child sexual abuse and trauma come into contact, survivors will lack the confidence necessary to access such services even when they are ostensibly available:

*'Without such a shift in both perspective and practice, the dictum to 'Do no harm' is compromised, recipients of mental health services are hurt and retraumatised, recovery and healing are prevented, and the transformation of mental health care...will remain a vision with no substance in reality' (Jennings, 2004: 60).*

The bottom line must remain the needs of individuals, prioritising client choice with survivors at the centre of any service process, and engaging families, friends, community members as well as workers, practitioners, agencies and policy makers to explore possibilities for optimal service provision. The key driver must be a 'no wrong door' principle whereby access to services means the right services in the right place at the right time.

In prioritising individual needs, consideration must be given to all elements of daily functioning including health and wellbeing, social connectedness, and participation. To achieve such outcomes will require coordinated care and support from service teams and practitioners to provide an integrated model of care, engaging multi-disciplinary teams and services with a shared understanding of needs and how best to meet them. Needless to say this will require coordination between service agencies, practitioners, and across sectors to build an integrated service model.

- **What type of service models help victims and survivors to receive the support they need?**

Warsaw and Moroney (2002) suggest that treatment models need to find ways of integrating service responses that reflect social and advocacy requirements, as well as psychological needs, and that issues around current as well as past abuse are addressed.<sup>xli</sup>

In addition to developing health and human services which are trauma-informed and extensive, training primary care practitioners to build understanding, recognition, and knowledge, expanded specialist face-to-face, telephone counselling and support as well as online services and educational workshops should be available to enable choice which meets diverse needs.

A significant proportion of survivors of institutional abuse may be reluctant to access face-to-face counselling, and certainly on initial contact. Provision of knowledge, information and tools from educational workshops as well as availability of an 'anonymous' specialist service which offers telephone and/or online information, counselling and support are additional very effective modes of service-delivery. Of course this also presupposes consistent availability of appropriately trained staff, adequate provision of supervision and quality assurance, and the capacity of all such services to be fully trauma-informed.

Appropriately moderated online forums and chat-rooms (for survivors in the first instance but also for family, friends, partners and loved ones) could also be a valuable component of online psychological service delivery. These could serve as both complement and alternative to availability of face-to-face therapeutic groups for survivors who experience complex trauma-related issues.

**A range of specialist services are outlined here below, all of which must always be subject to compliance with the `gold standard' of trauma informed practice:**

- Face-to-face (individual counselling and psychotherapy) provided by trauma-informed practitioners with expertise and experience in working with complex trauma survivors (*'Therapy should be tailored and individualized; one size does not fit all'; 'Adapt the therapy to the client rather than expecting the client to adapt to the therapy'; Practice Guideline 14; ref. Rothschild, 2011).*

*"Thank you again for ASCA - the counsellors are an amazing team of people, and the research you do is invaluable - I take it with me now to my sessions to educate my therapists."* Anonymous ASCA 1300 caller

- Professional telephone and online counselling and support services (i.e. dedicated specialist services staffed by appropriately trained health professionals as per the ASCA 1300 Professional Support Line) to provide short term counselling, support, information, referrals for ongoing therapeutic or counselling support. It appears that people with severe abuse histories, many of whom experience a strong sense of shame and relationship difficulties, find it easier to call a telephone line or email for information and support as these modes of engaging are more anonymous.

*"I spoke with one of your counsellors yesterday, struggling to even know where to start, but eventually identifying that the extensive neediness I'm experiencing following a recent injury, along with feeling so isolated has just seriously triggered my prior child abuse issues. I had thought that I had resolved much of it years ago and wasn't so affected by it anymore but it's all come back the last couple of months big-time. Your counsellor was just phenomenal. His depth of understanding was powerful and I felt so Seen and Understood; I felt like he really got it and although it made me cry initially, it was so deeply soothing and relieving. It's so rare for someone to truly get the impact; it was just amazingly potent and liberating....And he helped me identify potential avenues with my current counsellor, who is lovely but perhaps not as familiar with adult survivors of child abuse. I ended the call feeling this intense sense of gratitude, as well feeling more energy than I've felt in months. But not just energy, also calmer and less anxious I feel like your counselling line has given me a way forward and a sense of hope. I don't think I've felt that understood in a very, very long time. I'm so blessed to have had the gift of this phone call. One hour and the right person on the other end of the phone and I cannot believe the difference it's made."*

*"Extremely sensitive to my cause. Validated my fears and anxiety were not my fault. That I am not alone and there are avenues I can take to start healing. S/he gave me all the time I needed to talk and made sure that I was feeling more centered and calm before we finished the call."* Respondent ASCA survey 2015

*“I feel so blessed to have found ASCA and been able to speak to the counsellors when I did. I am only just beginning to remember or acknowledge things that have happened to me. Knowing that [ASCA} are there every day, every single day, gives me great comfort. More security than I ever had. Actually they are the only support I have ever had. Strangers on the phone yet somehow know me better than those closest to me.” Respondent ASCA survey 2015*

- Availability of specialist professional and online counseling and support services during extended hours and times of need

*“Personally, I have found that it's often after hours, in the evenings or at night that I need to talk to someone. Unfortunately ASCA's help line is unavailable. I have called other services instead, however would much rather talk to the people who understand the complexities of CSA. When I did speak to someone during the day, my experience was nothing but positive.” Respondent ASCA survey 2015*

- Central registry/referral database managed by a specialist organisation with expertise in supporting adult survivors – to include register of trauma informed primary care practitioners, complex trauma clinicians, trauma informed generalist and specialist agencies, trauma informed supervisors – clinical and non-clinical

*“ It was only last September when I discovered the ASCA website and I will never forget the feeling of support and empathy that I received when I finally made the first phone call to ASCA, which was also the first time I had ever spoken about my abuse. It was also during this call that I was given the number of a local psychologist and for this I am very grateful, as I have been seeing her regularly since then and she has been of tremendous help.”*

*“I started seeing a psychologist weeks after I called ASCA. I have been extremely satisfied with my therapy. I have gained the courage to call the police and make a statement. My journey has just started and although I am nervous about the preceding court case- I am much happier to be 'doing' something about my problems rather than being consumed with anxiety for the last 40 years. All thanks to the guidance from my therapist.” Respondent to ASCA survey 2015*

- Registry of agencies providing comprehensive case management to adult survivors of complex trauma, including child sexual abuse, which coordinate service responses to their mental, physical and psychosocial needs. The need for effective ongoing case management options cannot be overstated.
- Professional call-back service specific to the needs of adult survivors of complex trauma, including child sexual abuse with scheduling of phone or online sessions with an experienced counsellor. Such a service would significantly enhance existing services, especially for clients who are psychologically or geographically isolated. A structured one-on-one call back service using phone, Skype, videoconferencing, and/or instant messaging services for rural and remote clients who have trouble accessing therapy is recommended.

- Educational workshops providing psycho-education to survivors and equivalent programs for family, friends, partners and loved ones in a safe and peer environment have been established to improve knowledge, insight, feelings of safety, self-understanding and self-care. They can also enhance access to support, resources, and tools, thus building awareness around possibilities for recovery and pathways to achieve it. Such workshops can also help reduce a sense of isolation and shame, and promote peer networks of support.

*“Group environment was more powerful for me than the counselling that I have been attending for years. I realise having counselling has helped me to get to this stage I am at now. However being in a group and hearing others have been through similar experiences helps me feel not as alone in this.”*

*“I am an adult survivor of child sexual abuse and have been in Casa counselling for approx 4 and ½ years and read countless publications to assist in living a whole and productive life. I believe the workshop provided me with not only validation (an integral part of recovery) but additional knowledge on why I am like I am. It gave me a feeling of not being alone. I can only reiterate how wonderful I found the workshop to be and look forward to attending as many as possible. Thanking you sincerely for assisting me in no small way to live not just survive.”*

*“(Trainer) gave me hope that it is actually possible for survivors to thrive - not just to recover but thrive! For me, that was a new concept. This was the first time that I have come together with other survivors and just being in a room with people who understood and were on the same page - as opposed to trying to figure stuff out all by myself - was quite a moving experience. Because we live in the country I have often felt very isolated on my journey, finding it hard to find good resources and understanding support. So once again, in appreciation I say "THANK YOU".*

*“Attending the ASCA Survivors Workshop was a light bulb moment for me. Haven't looked back since. Every day now I look forward. It was the day I completed the jigsaw fragments of a painful and dark existence, to making sense. Since then I have been working hard to make up for what I missed out on and I'm enjoying every minute of it! Life has become very good, fulfilling and heaps of fun.”*

- Online resources including web tools, resources and links, fact sheets, videos, webinars for survivors and their supporters, and online workshops for family, friends, partners and loved ones

*“This is an important issue and the website is an essential element in providing people with information and advocacy. It helps survivors to know they are not alone and to access support, and it helps health and welfare professionals to access high quality information and professional support.” Respondent ASCA survey 2015*

*"I think it is a brilliant website. I cannot tell you how important it was for me to watch the videos in particular and hear firsthand stories about how childhood abuse has affected those who were brave enough to share their stories. Because of these wonderful people, I am now more open to sharing my own experiences, and hopefully educating those who have never been affected by abuse."* Respondent ASCA survey 2015

*"I have read these for personal and professional interest and found them wonderful. I have also distributed them in my community sector workplace and had great feedback about the fact sheets."* Respondent ASCA survey 2015

*"I struggle to talk about the Childhood Sexual Abuse so email or reading the website works better than a phone call."* Respondent ASCA survey 2015

- Online psychological support services which could potentially include expertly moderated peer-to-peer forums and chat rooms in addition to ongoing capacity for professional responses to individual survivors (as per above). *The importance of peer relationships and networks cannot be overstated; nor can the effective moderation of such forums to establish and maintain safety. Peer relations can also be developed as a benefit of a group program and be extended with the ongoing delivery of professionally managed follow up group sessions.*
- Therapeutic groups (expertly co-facilitated, closed and potentially organised according to the point/phase at which participating members are located in their individual healing journeys). Therapeutic groups can also be a particularly powerful adjunctive modality for trauma survivors if patients are carefully screened for a group that matches their stage of treatment. Subject to screening and expert trauma-informed facilitation, participation in a psychotherapeutic group can foster safety, self-understanding, and reduction of isolation, shame and related cognitive distortions.
- Trauma informed inpatient programs which are an adjunct to therapy, minimising the risk of re-traumatisation and which provide safety and possibilities for stabilising for the more unwell client.
- Trauma-informed telephone and online counselling and support services, face-to-face counselling and psychotherapy, groups for families, partners of survivors
- Trauma informed workshops for family, friends, partners and loved ones help supporters learn to use a trauma-informed approach to interpersonal communication and relationships. They also assist them to acquire the knowledge, insight and hope they need to prioritise their own self-care while supporting their survivor loved ones to recovery.

*"At last there is some sound education and empathic support for individuals and partners impacted by such gross boundary violations."*



- Parenting services and resources to help break the cycle of abuse and trauma. Existing parenting programs while effective in mainstream populations are often inadequate as they do not address the specific wounds and issues of child abuse survivors who become parents.
- Supervision, case consultation and debriefing

Trauma-informed supervision, case consultation and debriefing is needed for all practitioners and other personnel who are:

- working clinically with adult survivors of complex trauma
  - supervising practitioners working clinically with adult survivors of complex trauma
  - working in a supporting (non-clinical role) with clients with experiences of past and/or present traumas
  - supervising non-clinical or support staff who work with clients with experiences of past and/or present traumas
- Trauma-informed organisational change – consultation and implementation

All aspects of service systems including policies, procedures, practice and support need to accommodate the vulnerabilities of trauma survivors. This allows services to be delivered in a way that will avoid inadvertent re-traumatisation, facilitate consumer participation in all aspects of the organisation and optimise their health and psychosocial outcomes. It also minimises the risk of vicarious traumatisation for staff and improves staff satisfaction, health and wellbeing, as well as organisational cohesiveness and productivity.

- Collaborative care where necessary and appropriate

Survivors may have contact with diverse health and human service professionals. Any support and psychological services facilitated under the redress scheme need to be able to promote collaborative care where appropriate. This entails collaboration not only with the client, but with the other professionals and services (e.g. prescribing physician) with which they may be in contact. The potential diversity of such collaboration will raise logistical challenges which need to be met at a systemic (as well as individual practitioner) level.

---

### **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?**

As per response to pt 2 above, the best means of ensuring the requisite skills to assist survivors of child sexual abuse and trauma is *mandated introduction of trauma-informed practice within all services and contexts with which survivors have contact.*

Depending on the service accessed (e.g. treatment and/or advocacy and support) the nature and duration of such contact will vary considerably.

Personnel who provide *therapy and treatment* to survivors require specialist skills, should be registered with the appropriate professional body/ies in their field (e.g. counselling, psychology, psychotherapy, social work) and undertake regular clinical supervision and ongoing professional development.

Personnel who act in *non-clinical* capacities (e.g. in advocacy and support services) should incorporate the principles of trauma-informed practice into all aspects of their role specifications and requirements.

ASCA believes that an accreditation process is needed for practitioners and services, with an accreditation body to assess competency and quality assure training, and a central registry of trauma-specific and trauma-informed services. ASCA also recommends ongoing assessment and review, which meets standards, adheres to trauma-informed principles and practice-based evidence methodology. This process should not be overly bureaucratic, expensive or intrusive of the therapeutic space.

At the level of treatment, it is not possible to overstate the importance of the requisite skill base on the part of the diverse health professionals who work with survivors:

*‘Both women and men with histories of trauma are commonly misdiagnosed and retraumatized by wrongful treatment....Such maltreatment exacerbates their condition and perpetuates their need for costly emergency, acute and long term mental health services...This misuse of taxpayers’ money and perpetuation of human tragedy must no longer be allowed to continue’(Jennings, <http://theannainstitute.org/a-bio.html>)*

Additional to formal knowledge base, skill base, and experience in provision of therapy/treatment for survivors must be the *relational capacities* of practitioners which research establishes to be critical. This was one of four themes identified by a phenomenological Australian study (Valencia, 2014) which investigated the components which either contributed to healing or, alternatively, to negative experiences of counselling on the part of clients who had experienced child sexual assault (the negative factors are referenced in response to Topic A [2] above). The *way in which* practitioners related to clients (‘their being with them’, *ibid*:18) and a process which was both reflective and challenging when needed were found to be important.

Thus alongside the appropriate training, ongoing professional development, and clinical supervision must be means by which *attentiveness to the dynamics of relationality* on the part of diverse practitioners can be both inculcated and maintained. For practitioners whose methods of working do not emphasise relationality as a key dimension of treatment per se (i.e. even when formal knowledge and skill base with respect to complex trauma is operative) this can best be facilitated via ongoing contact between diverse professionals in the field. In this context, professional development – potentially coordinated by a body of the kind suggested above - for diverse practitioners who offer treatment/therapy for survivors should be considered.

*All personnel of all services (i.e. whether public or private; irrespective of occupation, qualifications, skill base and level of experience) should perform their work in a trauma informed manner. This should be facilitated by the undertaking of basic training in trauma-informed practice which is tailored to the nature of the work performed and which can be followed up and supplemented as necessary.*

*If the needs of survivors are to be adequately met, it is essential that service-wide trauma-informed practice becomes the norm.*

---

## 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 is now a rich and rapidly growing body of approaches/modalities which, subject to their active incorporation of key clinical and research insights in relation to complex trauma (*'[e]ffective therapy for trauma involves the facilitation of neural integration'*; Siegel, 2003:xviii) are rightly diverse.

One such area is that of somatic and sensorimotor approaches (*'[m]odern neural science clearly points to the central role of the body'*; Siegel, 2009:xv). In their capacity to tap 'right brain' non-verbal responses, body-based approaches can potentially redress some of the limits of traditional 'talk' (psycho)therapies (*'The body, for a host of reasons, has been left out of the 'talking cure'*; Ogden, 2009:xxvii).

The Australian Childhood Foundation, in partnership with the Sensorimotor Institute of the United States, now offers courses for health, education, and welfare professionals who seek to enhance their practice 'beyond talk-based interventions' <http://www.childhood.org.au/for-professionals/vocational-training/therapeutic-courses/sensorimotor-psychotherapy-institute-courses> The rationale for these courses is the growing realisation 'that the body holds many cues and after-effects of abuse and violence and that whilst traditional therapy addresses the cognitive and emotional elements of trauma, it can lack techniques that work directly with the physiological elements' (ibid)

Sensorimotor psychotherapy represents a particularly influential approach among the many (and very diverse) 'body-based' orientations to treatment of complex trauma which now exist. The ACF-US partnership – which incorporates key web-based technologies - is increasingly accessible to the diverse practitioners it aims to serve. Accessibility of innovative approaches to therapy/treatment for complex trauma is far from the norm however. On the contrary, availability of the core skill and knowledge base in this area to the wide spectrum of practitioners who require it remains an urgent and unmet goal.

Ongoing access to the insights of evolving clinical practice and research is essential. ASCA is represented on the Scientific Committee of the International Society for the Study of Trauma and Dissociation

(ISSTD), from which it is apprised of, and also contributes to, international publications in the field. Research insights are disseminated via ASCA trainings, Factsheets, and updated web listings.

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

In addition to 'body based' approaches as noted above, Eye Movement Desensitization and Reprocessing (EMDR) deserves particular mention. EMDR is now one of the most researched psychotherapeutic treatments ( [www.emdraa.org](http://www.emdraa.org) , [www.emdria.org](http://www.emdria.org) , [www.emdr-europe.org](http://www.emdr-europe.org) ) It is endorsed by a number of national and international bodies which include the National Health and Medical Research Council (2007), the UK National Guidelines for Clinical Excellence (NICE 2005) and the World Health Organisation (2013).

EMDR is found to be highly effective in intercepting how the brain processes information. Given that stressful experience – and especially traumatic memory – becomes 'frozen in time', the potential benefits of this approach for trauma therapy and treatment are considerable. Subject to assessment of its suitability (i.e. for individual clients) aftereffects of an EMDR therapy session can be that 'people no longer relive the trauma or feel disturbed when they think about it. Flashbacks and nightmares cease. They still recall what happened, but it is not as upsetting' (EMDR Therapy, 2015).

With respect to trauma-informed practice within services, Jennings (2004) describes 'over 50' service models reported to be implemented in the United States. While not all researched fully, in combination they suggest 'a significant increase in the number of trauma-informed and trauma-specific services and models which are *applicable, replicable, and appropriate for use in public sector service settings*' (ibid, p,14; emphasis added). In this context, Jennings speaks of 'emerging best practices' applicable to public mental health and substance abuse systems; a formulation which captures the dynamic evolution of work in this area as well as the 'positive client outcomes' which some service models have been found to achieve (ibid)

A range of service models now exist for clients of public mental health and substance abuse services who have been traumatised by interpersonal abuse in childhood and/or adolescence. Many of these models have been specifically designed to address complex traumatic stress issues (Jennings, 2004:5). As described by Jennings, these include:

- Models for Developing Trauma-Informed Service Systems and Organizations
- Individual Trauma-Informed Service Models
- Trauma-Specific Service Models for Adults
- Manualised Adaptations to Trauma-Specific Service Models for Adults
- Trauma-Specific Models for Parenting
- Trauma-Specific Models for Children
- Trauma-Specific Peer Support and Self Help Models (ibid)

Mindful of the different national context of the United States (in which the majority of the above service models operate) there now exist considerable resources which, with appropriate adaptation in light of contrasting treatment settings, can be implemented in the Australian context.

While some Australian services are beginning to embrace trauma-informed principles, it is 'early days' as far as widespread implementation of them is concerned. Such principles are yet to be adopted more broadly by mental health services, and in the public health system the medical model remains dominant. There is now, however, a wide range of materials in the area of trauma-informed practice, particularly from the US, including toolkits, protocols and worksheets which are available for download (see, for example, Guarino et al, 2009). ASCA's *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* also reference some of this material.\*

The above attest to the now large reservoir of material in the area of trauma-informed practice on which to draw in the necessary and now urgent project of its service-wide implementation.

---

### **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?**

Development of therapies and treatment modalities for survivors of complex childhood trauma is proceeding apace. The rapidity of this development is such that many of these orientations have yet to be formally researched in a context where many skilled clinicians do not engage in research in any case. The orientation of 'practice-based evidence' (as distinct from the more familiar concept of 'evidence based practice') is gaining ground for this reason (for discussion of the nature and significance of these terms, see the 'Glossary' of ASCA's *Practice Guidelines for Treatment of Complex Trauma* (ibid))

The point can be illustrated with reference to a treatment handbook which presents a wide array of trauma therapies (Shapiro, 2010). Many of these are avowedly not researched. But their clinical utility is attested to by the author who is an experienced trauma clinician. That widely respected researcher and clinician Daniel J. Siegel MD wrote the Foreword to this text – and endorsed its contents even in the absence of scientific evidence for some of the modalities included – also attests to the importance of wide knowledge and availability of developing approaches which may be highly clinically efficacious in the absence of the 'standard' evidentiary base (ibid).

As specialists in treatment of complex trauma underline, our understanding of the neurobiology of trauma and attachment is expanding to an extent that clinical practice needs to 'catch up' to ensure wide availability of therapies which are informed by these insights (Fosha, 2003:276). ASCA's 2015 *Economic Report: Addressing the Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* has established the economic imperative for this to occur. In engaging with governments, ASCA recommends serious consideration of the significant ongoing costs of not adequately addressing the counselling and psychological needs of institutional child sexual abuse survivors.

We are now aware of too many deficiencies within delivery of mental health services in this country (suicidal people turned away from emergency departments; insufficient follow up and treatment) to

deny the need for trauma specific modalities and trauma informed services to the Australian context. As our response to the Issues Paper and the appended reference list attests, the growing material in both these areas is now numerous and continues to expand.

**KEY PRINCIPLES FOR WORKING WITH ADULT SURVIVORS (ABBREVIATED ASCA GUIDELINES)\*** For the complete and detailed set of ASCA clinical guidelines for treatment of complex trauma, see [www.asca.org.au/guidelines](http://www.asca.org.au/guidelines)

- 1. Safety:** Facilitate emotional & physical safety at all times\*
- 2. Stabilisation:** Foster affect tolerance at all times\* (*precondition & requirement for all interventions and stages*)
- 3. Recognise impacts:** Comprehensive impacts of childhood trauma, attune to 'the whole person'
- 4. Strengths-based approach:** Regard 'symptoms' as outgrowths of coping mechanisms
- 5. Understand the basic regions of the brain:** Effects of trauma & stress on the brain. Provide 'user friendly' psycho-education as appropriate
- 6. Arousal reduction techniques:** Attune to 'bottom up' as well as 'top down' brain processes, recognise adult survivors are vulnerable to 'bottom up' (lower brain stem) responses
- 7. Therapy should be *phased*:** (*Phase 1: stabilisation; Phase 2: processing; Phase 3: integration*) & the importance of Phase I recognised at all times
- 8. Attune to *attachment* issues at all times**
- 9. Acknowledge prevalence of *dissociative* responses:** Recognise the difference between *hyper* and *hypo*arousal, and the need to stay within 'the window of tolerance'
- 10. Support networks:** Encourage establishment/strengthening of these as appropriate
- 11. Embed & apply understanding of complex trauma in all interactions**
- 12. Attune to client diversity in all its forms & tailor therapy appropriately**
- 13. Engage in regular professional supervision**
- 14. Maintain & convey optimism about recovery as consistent with research findings in the neurobiology of attachment**

## References

- Bloom, S.L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press).
- Bloom, S.L. (2006) 'Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation' (Alexandria, VA: National Technical Assistance Center).
- Boon, Suzette, Steele, Kathy, & Van der Hart, Onno (2011) *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* (New York: Norton).
- Briere, John & Scott, Catherine (2006) *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment* (London: Sage).
- Brown, Laura S. (2009) *Cultural Competence in Trauma Therapy* (Washington, DC: American Psychological Association).
- Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults. Retrieved from [http://www.istss.org/ISTSS\\_Expert\\_Consensus](http://www.istss.org/ISTSS_Expert_Consensus).
- Courtois, Christine A. & Ford, Julian D. (2009) *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (New York: The Guilford Press).
- Cozolino, Louis (2002) *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain* (New York: Norton).
- Davis, S. et al (2006) 'Identifying and targeting predictors of drop-out from group cognitive behaviour therapy', *Australian Journal of Psychology* (58, 1, 48-56).
- Crotty, E. (2011) 'Supervising Through Cyberspace' *The CAPA Quarterly* (Issue Three, pp.26-29).
- Daniel, L. (2011) 'The Face on My Computer Screen: A Client's Experience of Therapy via Skype', *The CAPA Quarterly* (Issue Three, pp.24-25).
- Doidge, Norman (2007) *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science* (New York: Viking, 2007).
- Erlhars et al. (2010) 'Do all psychological treatments all work the same in post-traumatic stress disorder?' *Clinical psychological review* 30, 269-276.
- Fallot, R. & Harris, M. (2009) 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol' (Washington, DC: Community Connections).
- Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. (2008). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. (2nd Edition ed.). New York: The Guilford Press.
- Gaurino, K. et al (2009) *Trauma Informed Organizational Toolkit* (Rockdale, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration).
- Jennings, Ann (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States.
- Kezelman, C.A. & Stavropoulos, P.A. (2012) *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (Sydney, Adults Surviving Child Abuse, 2012. [www.asca.org.au/guidelines](http://www.asca.org.au/guidelines))
- King, R. (2013) 'Psychological services under Medicare: Broken but not beyond repair'. *Psychotherapy in Australia* (Vol.19, No.2).
- Leichsenring F., Leibing E. (2003) 'The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis', *American Journal of Psychiatry* 160(7):1223-32.
- Levine, P. (2010) *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness* (Berkeley, CA: North Atlantic Books).
- Loewenstein, R., Brand, B. et al (2014) *Treating Complex Trauma Survivors* (October 2014) <http://www.psychiatrytimes.com/print/20163>
- Rothschild, B. (2011)
- McDonagh et al (2005) 'Randomised trial of cognitive-behavioural therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse', *Journal of Consulting and Clinical Psychology* (73, 3, 512-524).
- Natrsoff, d.S. & Draucker, C.B. (2005) Psychotherapy approaches for adult survivors of childhood sexual abuse: An integrative review of outcomes research *Issues in Mental Health Nursing*, 26, 801-825.
- Ogden, Pat, Minton Kekuni & Pain, Clare (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (New York: Norton).
- Randall, Melanie & Haskell, Lori (2013) 'Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping', *The Dalhousie Law Journal* (Fall, 523-533).

- Rothschild, Babette (2011) *Trauma Essentials: The Go-To Guide* (New York: Norton).
- Schnur et al. (2007) 'Cognitive behavioural therapy for post-traumatic stress disorder in women: a randomised control trial', *JAMA* 297:820-830.
- Shapiro, Robyn (2010) *The Trauma Treatment Handbook: Protocols Across the Spectrum* (New York: Norton).
- Solomon, Marion T. & Siegel, Daniel J. (2003) *Healing Trauma: Attachment, Mind, Body and Brain* (New York: Norton).
- Taylor, J.E. & Shane, S.T. (2010). A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood. *Clinical Psychology Review* 30, 749-767.
- Toporek, R. et al (2006) *Handbook for Social Justice in Counselling Psychology* (Thousand Oaks, CA: Sage).
- Valencia, S. et al (2014) 'What aspects of counselling facilitate healing for childhood sexual assault for men and women? A phenomenological investigation (Psychotherapy in Australia (Vol 20, No 4).
- Van der Hart et al (2006) *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (New York: Norton).
- Van de Kolk et al. (2007) 'A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance', *Journal of Clinical Psychiatry*, 68 (1):37-46.
- Van der Kolk, B.A. (2005) 'Developmental Trauma Disorder', *Psychiatric Annals*. 2005 pp. 401-408
- Van De Kolk, D.A. (2014) *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* (New York: Viking).
- Van der Kolk, B.A. et al (2014) 'Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomized Controlled Trial', *Journal of Clinical Psychiatry*, 75(6), e559-e565.

- 
- <sup>i</sup> Kezelman, C.A. Stavropoulos. P. A. (2012) Practice Guidelines for Treatment of Complex Trauma and Trauma Informed care and Service Delivery. Adults Surviving Child Abuse
- <sup>ii</sup> Kezelman, C., Hossack, N., Stavropoulos, P., Burley, P., (2015) The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia, Adults Surviving Child Abuse and Pegasus Economics, Sydney
- <sup>iii</sup> Kezelman, C.A. Stavropoulos. P. A. (2012) Practice Guidelines for Treatment of Complex Trauma and Trauma Informed care and Service Delivery. Adults Surviving Child Abuse Executive Summary Kezelman C p.xxviii
- <sup>iv</sup> Kezelman, C., Hossack, N., Stavropoulos, P., Burley, P., (2015) The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia, Adults Surviving Child Abuse and Pegasus Economics, Sydney p.8
- <sup>v</sup> Ibid p.9
- <sup>vi</sup> Kezelman, C.A. Stavropoulos. P. A. (2012) Practice Guidelines for Treatment of Complex Trauma and Trauma Informed care and Service Delivery. Adults Surviving Child Abuse Newman L. v.
- <sup>vii</sup> Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). The haunted self: Structural dissociation and the treatment of chronic traumatization. New York: W. W. Norton, p.304
- <sup>viii</sup> Kezelman, C.A. Stavropoulos. P. A. (2012) Practice Guidelines for Treatment of Complex Trauma and Trauma Informed care and Service Delivery. Adults Surviving Child Abuse. Foreword Stillwell T. p.viii
- <sup>ix</sup> Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults. Retrieved from [http://www.istss.org/ISTSS Expert Consensus](http://www.istss.org/ISTSS%20Expert%20Consensus).
- <sup>x</sup> Ibid pp 5-6.
- <sup>xi</sup> Ibid. Richard Loewenstein, MD [4], Bethany Brand, PhD [5], Lauren E. Gilbert, MA [6], Christen E. Dressel, MA [7], Joshua S. Camins, MA [8], and Zachary J. Pyne, MA Treating Complex Trauma Survivors (October 2014) <http://www.psychiatrytimes.com/print/20163> Rothschild, B. (2011) *Trauma Essentials*. New York: Norton, 57; Courtois, Ford & Cloitre, ibid, p.98.
- <sup>xii</sup> Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', ibid, pp. 96-7.
- <sup>xiii</sup> Taylor, J.E. & Shane, S.T. (2010). A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood. *Clinical Psychology Review* 30, 749-767
- <sup>xiv</sup> Natrsoff, d.S. & Draucker, C.B. (2005) Psychotherapy approaches for adult survivors of childhood sexual abuse: An integrative review of outcomes research *Issues in Mental Health Nursing*, 26, 801-825
- <sup>xv</sup> Van De Kolk (2014) *The Body Keeps the Score: Mind and Body in the Transformation of Trauma*, pp347-348
- <sup>xvi</sup> Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. (2008). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. (2nd Edition ed.). New York: The Guilford Press.
- <sup>xvii</sup> Cloitre, M., Courtois, C.A., Charuvastra, A. Carapezza, R. Stolbach, B.C., & Green, B.L. (2011).



- Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress*, 24, 615-627.
- Van der Kolk Developmental Trauma Disorder *Psychiatric Annals*. 2005 pp. 401-408.
- <sup>xxviii</sup> Cloitre, M., Courtois, C.A., Charuvastra, A. Carapezza, R. Stolbach, B.C., & Green, B.L. (2011).  
 Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress*, 24, 615-627.
- <sup>xix</sup> Australian Center for Posttraumatic Mental Health, 2007; International Society for the Study of Trauma and Dissociation, 2011; National Institute for Clinical Excellence, 2005; American Psychological Association Division 56 (Trauma Psychology); International Society for the Study of Trauma and Dissociation
- <sup>xx</sup> Cloitre, M., Stovall-McClough, K. C., Noonan, K., Zorbas, P., Cherry, S., Jackson, C. L., et al. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry*, 167, 915-924.
- <sup>xxi</sup> Cloitre, M., Courtois, C.A., Charuvastra, A. Carapezza, R. Stolbach, B.C., & Green, B.L. (2011).  
 Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress*, 24, 615-627.
- <sup>xxii</sup> Van de Kolk et al. A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *J Clin Psychiatry*. 2007 Jan;68(1):37-46.
- <sup>xxiii</sup> Van de Kolk B., The Body Keeps Score. Conference presentation Sydney 2015
- <sup>xxiv</sup> Schnur et al. Cognitive behavioural therapy for post-traumatic stress disorder in women: a randomised control trial *JAMA* 297:820-830, 2007
- Van de Kolk et al. A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *J Clin Psychiatry*. 2007 Jan;68(1):37-46.
- <sup>xxv</sup> Van de Kolk B., The Body Keeps Score. Conference presentation Sydney 2015
- <sup>xxvi</sup> Erhlers et al. Do all psychological treatments all work the same in post-traumatic stress disorder? *Clinical psychological review* 30 (2010) 269-276
- <sup>xxvii</sup> Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. In C. Courtois & J. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence based guide* (pp. 312–328). New York: Guilford.
- <sup>xxviii</sup> Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomized Controlled Trial  
 van der Kolk, Stone, West, Rhodes, Emerson, Suvak, Spinazzola, *Journal of Clinical Psychiatry*, 75(6), e559-e565, 2014.
- <sup>xxix</sup> Vilencia et al. What Aspects of Counselling Facilitate Healing from Childhood Sexual Assault for Men and Women? A Phenomenological Investigation *Psychotherapy in Australia* - August 2014 , Vol 20 No 4
- <sup>xxx</sup> Leichsenring F., Leibing E. The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. *Am J Psychiatry*. 2003 Jul;160(7):1223-32.
- <sup>xxxi</sup> NASASV. (1998). National Standards of Practice Manual: for services against sexual violence. Centre Against Sexual Assault (CASA), Royal Women's Hospital, Women's & Children's Health Care Network: Vic, Australia. Cited MHCC (2006) *Reframing Responses - Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems Report and Recommendations*
- <sup>xxxiii</sup> NASAV. (2002). Cultural Diversity and Services Against Sexual Violence. National Association of Services Against Sexual Violence (NASASV). CASA House & Royal Women's Hospital. Cited MHCC (2006) *Reframing Responses - Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems Report and Recommendations*
- <sup>xxxiv</sup> *ibid*
- <sup>xxxv</sup> Lievore, D. (2003). Non-reporting and hidden recording of sexual assault: An international Review. Report prepared by the Australian Institute of Criminology for the Commonwealth Office of the Status of Women: Commonwealth of Australia, Canberra.
- <sup>xxxvi</sup> Coorey, L. (2001). Child Sexual Abuse in Rural and Remote Australian Indigenous Communities: A Preliminary Investigation. Canberra: Government of Australia.
- <sup>xxxvii</sup> In NASAV. (2002). Cultural Diversity and Services Against Sexual Violence. National Association of Services Against Sexual Violence (NASASV). CASA House & Royal Women's Hospital, p.15.
- <sup>xxxviii</sup> <http://www.aihw.gov.au/rural-health-impact-of-rurality/>
- <sup>xxxix</sup> Australian Institute of Health and Welfare 2014. Australia's Health 2014. Australia's health series no 14 Cat no: AUS, 178, Canberra, AIHW
- <sup>xl</sup> Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...', p.66.

---

<sup>xli</sup> Warhsaw,C. & Moroney,G. (2002). Mental health and domestic violence collaborative initiatives, service models and curriculum. Working Paper: Chicago. Available: <http://www.dvmhpi.org/>