

Adults Surviving Child Abuse (ASCA) www.asca.org.au

ASCA is the leading national organisation working to improve the lives of Australian adults who have experienced childhood trauma. This includes child abuse in all its forms (sexual, emotional, physical; neglect), domestic violence in childhood and other adverse childhood events.

Childhood trauma is 'complex' trauma (i.e. cumulative, underlying, and largely interpersonally generated, contrasting it to single-incident trauma. The impacts of complex trauma are more extensive than those for single-incident PTSD¹. When unresolved, childhood trauma, including child sexual abuse, erodes physical and psychological health in adulthood unless specifically targeted and actively addressed.

The work of ASCA informs policy and practice as well as workforce development and systems' change, nationally and internationally. In its submission to the Royal Commission for Institutional Responses to Child Sexual Abuse Consultation Paper on redress and civil litigation, ASCA would like to make reference to 2 major documents it has recently released:

1) *ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Service Delivery* (2012)

2) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* (2015)

¹ Courtois & Ford, ed. (2009) *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. New York: The Guilford Press, pp. 82-103.



1) ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery

In 2012 ASCA released a set of *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*². These guidelines present clinical and research insights of the last two decades of national and international research in the trauma field. They have been widely acclaimed both in Australia and overseas and have revolutionised possibilities for recovery for the large numbers of people who have experienced ‘complex trauma’, including child sexual abuse.

Identifying and appropriately addressing the needs of people who have experienced trauma in childhood is a major global *public health challenge*. Thus responses to its many impacts need to be informed and pertinent.

“I think about not only what cost it was to me and my family because professionals did not have the training to understand my issues, but what it cost the government in trying to “deal” with me while I was wrongly diagnosed” (Tamara Stillwell, mental health consumer, community worker).

Adverse and traumatic experiences in childhood are very common and child sexual abuse within institutions is a pervasive reality. Children growing up with such experiences struggle to feel safe and secure, at risk of profound long-lasting effects on their health, wellbeing and social functioning. The legacy of such trauma also affects their families, friends and communities, and - if they are parents - their children, as well.

Professor Louise Newman (Psychiatrist and Director of the Centre for Developmental Psychiatry & Psychology at Monash University) underlines that *“Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches.”*

² 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.



The ASCA *Guidelines* present the evidence base needed to translate research into practice. They establish a framework that responds to the national health challenge of trauma, and set the standards in the following domains:

A. *'Practice Guidelines for Treatment of Complex Trauma'* address the *clinical* context. They apply to *diverse health professionals* (psychologists, psychotherapists, psychiatrists, mental health social workers, counsellors and others) who work therapeutically in one-to-one relationships with people who experience complex trauma-related issues. These clinical guidelines reflect growing insights into the role of trauma in the aetiology of mental illness and new possibilities for clinical treatment.

B. *'Practice Guidelines for Trauma Informed Care and Service Delivery'* are directed to *services* with which people with trauma histories come into contact. In contrast to the clinical guidelines, these service/organisational guidelines do not presume or require clinical knowledge. Rather, they speak to *diverse personnel across all levels of human service settings* (e.g. intake workers, reception, front-line workers, hospitality) who have in common some kind of contact with clients who have trauma histories.

The high prevalence of unresolved trauma in the community means that a diverse array of staff, workers, and volunteers in a range of service settings will, often unknowingly, have direct and indirect contact with people who experience the impacts of overwhelming and unresolved stress. This means that there exist multiple and ongoing opportunities for interactions with clients. These can be either soothing and validating or exacerbating of stress. While non-clinical staff clearly cannot 'treat' trauma, what they can do – *and what we all need to do* – is interact with clients and our fellow citizens in ways which are affirming and which do not compound unresolved trauma which, as we know is highly prevalent in the population.

Research shows that clinical treatment of complex trauma needs to be both 'top down' and 'bottom up' (i.e. address all dimensions of the person as is consistent with development of different areas of the brain).³ Correspondingly, if *services and organisations* are to operate in a trauma-informed manner, they

³ Ogden et al (2006) *Trauma and the Body*. New York: Norton.



need to do so in a 'bottom up' and 'top down' manner as well. This involves all service personnel – from frontline and reception to senior management – and all procedures, policies and interactions, formal and informal. The second set of ASCA *Guidelines* is addressed to these service and organisational contexts.

“The first set of guidelines address the foundations of adequate and state of the art treatment; the second tackle the system of care, long known to be inadequate and stigmatizing to the traumatized. Both guidelines show how treatment and service delivery can be humane, trauma-focussed and trauma-informed to the benefit for all. This document is a singular and pioneering achievement in its depth and scope. .” Christine A. Courtois, PhD, ABPP, Psychologist Washington, DC.

The ASCA submission to the Consultation Paper derives from the evidence base presented in the ASCA *Practice Guidelines*.

2) The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia

In its recently released report: *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*⁴, ASCA built on the work presented in its *Practice Guidelines*, highlighting the need for ‘active timely comprehensive intervention’ to address the public health issue of trauma.

While the costs’ paper focussed on childhood trauma more broadly, the recommendations are acutely pertinent to the broad-based responses needed for adult survivors of institutional child sexual abuse. The research around child sexual abuse is both robust and compelling. Additionally many victims of child sexual abuse within institutions have experienced other forms of abuse, neglect, deprivations and violations concurrently as well. Hence the recommendations in ASCA’s report directly relate to the lived experience of the survivor group defined under the Terms of Reference for the Royal Commission into Institutional Responses to Child Sexual Abuse.

To deliver comprehensive, effective, and timely intervention, four service approaches were outlined. Listed below and discussed more fully in Appendix A, these four service approaches inform many of ASCA’s responses to the specific issues raised in the Commission’s Consultation Paper:

1. Active investment in specialist services

Specialist services are needed to spearhead policy and practice responses in relation to adult childhood trauma and abuse survivors. This requires active investment which supports a coordinated comprehensive model of care including continued and increased access to assistance and treatment through effective help lines and online services.

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

⁴ 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



When survivors resolve childhood trauma they are freed to live productive, healthy and constructive lives, as are their children.⁵

2. More and better trained treating practitioners - counsellors/therapists

Counsellors/therapists must be specifically trained to deal with the complexity of the issues involved. Counselling and therapy must also be accessible and affordable throughout the country. Widespread investment in training supported by a program to accredit practitioners of a range of disciplines is also recommended for consideration. Unless diverse practitioners are attuned to and skilled regarding the multiple and specific needs of adults who experience the impacts of childhood trauma, further harm can be done. Sadly we know that re-traumatisation can occur *within the very services accessed by adult survivors for support*.⁶ Hence the vital need for appropriate training and regulation of practitioners, and for all personnel who come into contact with survivors to operate in a trauma-informed manner (the latter context addressed in the second set of ASCA *Guidelines* as above).

3. A convenient and failsafe pathway to treatment – No wrong door

Frontline practitioners: General Practitioners and nurse practitioners will, on a daily basis, inevitably see people impacted by childhood trauma. Thus there are multiple and ongoing opportunities to facilitate a process whereby the presenting person can start receiving appropriate support. Such support may be direct or via targeted referral (including specialist counselling/therapy from an accredited and/or appropriately qualified practitioner).

4. System, service and institutional improvements - Trauma-informed practice

Benefits can also be achieved by minimising re-traumatising practices within institutions, organisations and agencies accessed by people who experience

⁵ 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.

⁶ Jennings, A. (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. United States: 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).

Davidson, J. (1997) *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions*. NSW Department for Women and the NSW Health Department.



the impacts of childhood trauma (see the second set of ASCA *Guidelines* as above). Essentially, trauma-informed practice seeks to create environments and 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* and *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 is good not only for clients but 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.⁷ This means that introduction of trauma-informed practice across and within services is also a partial preventative of staff alienation, disengagement and burn-out, and the enormous 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 yield to the benefits of enhanced work motivation.

With active early and comprehensive intervention - appropriate support, specialist treatment and trauma-informed practice interventions - adult survivors of childhood trauma and abuse can lead healthy, positive and productive lives. Their children, too, will benefit, because the resolution of trauma in parents intercepts its transmission to the next generation⁸.

As the analysis and estimates of ASCA's 2015 *Cost of Unresolved Childhood Trauma* report attest, making these services widely available and affordable would reap substantial cost savings and continuing benefits society wide.

⁷ 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.

⁸ Siegel, D.J. 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Solomon & Siegel, *ibid*, pp.1-56.



Recognition of this needs to be kept front and centre when considering the true costs of 'counselling and psychological care' recommended as part of any proposed Redress Scheme.

The opportunity to make recommendations around counselling and psychological care through redress provides a unique opportunity to review and develop a much-needed *comprehensive service system*. The consultation paper acknowledges that 'there are many government and non-government generalist and specialist services and practitioners which provide counselling and psychological care to survivors'. The AIFS⁹ 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.

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 or 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.*

⁹ Child sexual abuse: Summary of adult survivors' therapeutic needs 26 August 2013 AIFS CFCA



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.*¹⁰

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 which 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 minimized or dismissed their feelings and experiences rather than listening empathically and validating them’*¹¹

¹⁰ Child sexual abuse: Summary of adult survivors’ therapeutic needs 26 August 2013 AIFS CFCA

¹¹ Dr Cathy Kezelman <http://cathykezelman.com/trauma-informed-care/359/>



ASCA SUBMISSION TO CONSULTATION PAPER

ASCA welcomes the opportunity to respond to the Consultation Paper on redress and civil litigation. Our main focus in our response relates to (1) 'counselling and psychological care', with an additional, albeit limited response related to (2) 'direct personal response'. We have not addressed the area of 'monetary payment' in this submission.

COUNSELLING AND PSYCHOLOGICAL CARE

(1) The Consultation Paper on Redress and Civil Litigation welcomes submissions in the area of 'counselling and psychological care' that discuss:

- Principles for counselling and psychological care
- Existing services and service gaps
- Principles for supporting counselling and psychological care through redress

'submissions on the relative effectiveness and efficiency of the options in meeting survivors' needs' (17; 131)

ASCA's response to the counselling and psychological care element of Consultation Paper: Redress and Civil Litigation is informed by:

- 1) ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery www.asca.org.au/guidelines
- 2) ASCA Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia (2015) <http://asca.org.au/About/Resources/Economic-Report.aspx>
- 3) AIFS: Summary of Adult Survivors Therapeutic Needs
- 4) Additional national and international research

PLEASE NOTE: *Our submission addresses existing services and service gaps first, following which review of principles for counselling and psychological care and the elements of an effective service system response are presented.*

A. Existing services and service gaps

Existing services for provision of psychological support adequate to meet the recovery needs of adult survivors of child sexual abuse are known to be few and the service gaps in this area are many. 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 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-traumatised. 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 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 systemic¹² :

¹² 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.*¹³

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.¹⁴

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.'*¹⁵

Holden¹⁶ 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:

¹³ <http://www.theannainstitute.org/a-bio.html>

¹⁴ Mental Health Coordinating Council 'Reframing Responses' Literature Review August 2006

¹⁵ 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

¹⁶ *Ibid* (2002:22)



- *'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.*
- *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.'*¹⁷

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.*¹⁸ 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'*.¹⁹ It is affirming to consider the ways in which introduction of the 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.²⁰ 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

¹⁷ 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

¹⁸ Keel, M., Fergus, L. & Heenan, M. (2005). *Home Truths: A Conference in Review*. ACSSA Issues (3) March 2005.

¹⁹ <http://www.theannainstitute.org/a-bio.html>

¹⁹ *ibid*

²⁰ *ibid*



training and responses from a wide spectrum of specialist services, including drug and alcohol and mental health services.²¹

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 equity²² 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'*.²³

a) 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.

b) Specialist services

While a small number of organisations around Australia provide counselling support for childhood sexual assault survivors, broadly speaking, the service needs of adult survivors have been perennially overlooked. This has improved somewhat as a result of investment related to the Royal Commission's work. However building specialist expertise is not a short-term proposition and the scale of the service gaps is substantial and long-standing. Far more still needs to be done.

²¹ WISN. (1996). A Submission to the Royal Commission into NSW Police Service Paedophile Segment. The Women Incest Survivors Network Inc.

²² Mental Health Coordinating Council 'Reframing Responses' Literature Review August 2006

²³ Foreword by Tamara Stillwell, ASCA *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, p.viii.



While specialist sexual assault services provide expertise and experience, they are unable to meet demand. In many cases people are exposed to long waiting periods before the service can be accessed. Prioritisation of recent sexual assaults over historical matters (a result 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 immediately urgent.

The need for specialist agencies, unique to the needs of this group of people, 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, and male survivors 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, as well as for survivors more generally is much needed.

Separate agencies dedicated to addressing of their 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.²⁴ 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 vital.

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

Meeting the unique diverse and complex needs of adult survivors requires consistent and committed focus. This is because, without adherence to a trauma-informed paradigm, failure to meet the needs of survivors and/or re-traumatisation is common.

ASCA has been providing specialist services to this group of Australians for 20 years, and is fully conversant with current clinical insights in relation to effective and innovative practice (indeed is recognised as a pioneer in this

²⁴ ACSSA . (2005). ACSSA talks to Sandra Basham of the Incest Survivor's Association. Australia: ACSSA Newsletter (8) June 2005.



regard).²⁵ Thus its place in the landscape of advocacy, direct service provision, policy, practice, and workforce development is critical to ongoing sector and service development.

²⁵ The ASCA *Practice Guidelines* were hailed as 'a world first', and were presented by Presidential invitation at the 29th Annual Conference of the International Society for the Study Of Trauma and Dissociation (ISSTD) in Long Beach, California, in October 2012.



c) Service gaps and system recommendations:

1. Primary care - engagement, education and training:

The potential for active engagement, education and training of practitioners within the Australian primary care system provides a unique opportunity to begin to address the public health challenge of unresolved childhood trauma.

Strong longitudinal and epidemiological data²⁶ exists (*'[r]elationships of this magnitude are rare in epidemiology'*²⁷) and suggests that on a daily basis and often unknowingly, primary care practitioners see a number of patients experiencing the cumulative effects of trauma. *Within primary care settings across Australia, the trauma of adverse childhood experiences and its many effects largely goes unrecognised, unacknowledged, misdiagnosed, and unaddressed.*

As Bloom and Farragher²⁸ 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 of trauma. In the absence of entertaining the possibility of underlying trauma in a high proportion of patients who present to primary care settings on a daily basis, and understanding of the public health challenge this represents, practitioners will remain unable to respond in an informed manner at the vital first contact point of client need.

²⁶ 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.

²⁷ 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.

²⁸ Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. New York: Oxford University Press, p.224.



2. Trauma screening

'If ever there were a need for true primary prevention, this is the area'.²⁹

A major recommendation related to primary care settings, as well as non-specialist services, is *introduction of trauma screening*. The ACE Study³⁰ 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 their 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.¹

'We have demonstrated in our practice that this approach [ie carefully designed questionnaires ...] is acceptable to patients, affordable & beneficial in multiple ways'³¹.

The development of a trauma screening tool for use within the Australian primary care system would build on overseas evidence which has established the benefits and applicability of this approach.

Recommendation 1:

Education and trauma-sensitive training of primary care practitioners across Australia around trauma-informed service responses should be prioritised

²⁹ 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 p.18.

³⁰ www.ACEStudy.org

³¹ 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 2:

Universal trauma screening aligned to preventative health screening initiatives should be developed and implemented throughout the Australian primary care system

It is proposed that education and training targeted to practitioner groups and focussed on the policy and practice requisites of trauma informed services are 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 would be of particular benefit to the cohort of survivors who are ambivalent in the first instance about accessing counselling and 'psychological' support, but who feel less unease about regular visits to the GP.

3. Trauma-informed practice as gold standard and orienting principle

Effective services for adult survivors should be increased in number, but should also operate according to the principles of trauma-informed practice which remain to be comprehensively introduced across the Australian health service sector as a whole. 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'.³²

Irrespective of both the structure and form psychological services to survivors take (e.g. stand-alone, Medicare, trust fund, mixed model) all need to be predicated on the principle of trauma informed practice.

³² Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary* (New York: Oxford University Press, 2011), p.15.



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 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.³³ 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 receive supervision which can assist them in so doing. *"Trauma-informed services are designed specifically to avoid re-traumatising those who come seeking assistance..."*³⁴

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 a safeguard against staff burn-out and stress. Within many organisations and agencies there is an absence of support for client services and for staff who

³³ van der Kolk, *ibid*; Jennings *ibid*.

³⁴ FalLOT & Harris, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol' (2009), p.2.



work with complex trauma.³⁵ This urgently needs to be redressed, because research shows that absence of such support at any level puts both clients *and* staff at risk.³⁶

One of the many benefits of trauma-informed practice is a decrease of the risks of vicarious traumatisation of 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`*³⁷).

Recommendation 3:

All psychological and counselling services delivered to survivors should be predicated on the principle of trauma-informed practice

Trauma-informed practice is the benchmark (`gold standard`) according to which all psychological services to survivors should be structured, organised, delivered, and assessed.

It should also serve as the orienting principle for consideration of the redress scheme both on its own terms and in the context of how/the extent to which psychological services provided under its aegis will relate to/be integrated with provision of psychological services in this country more broadly (ie given the high number of survivors who may not identify or be perceived as such but who present to mainstream health services with trauma-related issues).

Contexts conducive to recovery

A context which facilitates healing is central to organisational practice which is trauma-informed. The *systemic* reforms this requires (ie across all aspects of service-delivery) reveal both the *intersectoral links* necessary for environments

³⁵ Laurie Ann Pearlman & James Caringi, `Living and Working Self-Reflectively to Address Vicarious Trauma`, in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, 212-213.

³⁶ Ibid, p.214.

³⁷ Bloom, S. L. (2006) `Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation`. Alexandria, VA: National Technical Assistance Centre. , p.2.



which are supportive of recovery, and the range and scope of the changes required:

*Changes to a trauma-informed organizational service system environment **will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently.***³⁸

As long as envisaged principles and practice are not simultaneously and explicitly trauma-informed – i.e. embedded into both the philosophy and functioning of all levels of service delivery – co-ordinated assistance towards client recovery will remain lacking.

Known within the trauma field for her 'Sanctuary' model of therapeutic community care and service-provision,³⁹ Sandra Bloom has recently co-authored a book which develops 'a trauma-informed, whole system approach to organizational change'.⁴⁰ Contending that the literature of organisational development 'is far ahead of the social service world in applying group concepts to the workplace',⁴¹ Bloom's marriage of trauma theory and organisational psychology challenges and expands conceptions of what 'whole system' change might look like.⁴²

The nature and specifics of the required changes are major:

The new system will be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history... open and genuine collaboration between provider and consumer at all phases of the service-delivery; an emphasis on skill building and

³⁸ Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services, p.15 (emphasis added)

³⁹ Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies* (New York: Routledge, 1997).

⁴⁰ Bloom & Farragher, *Destroying Sanctuary* (2011).

⁴¹ Bloom, 'Organizational Stress...', p.2.

⁴² Such chapter headings as 'Organizational Learning Disabilities...' and 'Miscommunication, Conflict and Organizational Alexithymia' convey the flavour of the striking 'individual'-'organizational' links which are forged.



acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than a single discrete event, and by a focus on what has happened to the person rather than what is wrong with the person... Without such a shift in the culture of an organization or service system, even the most 'evidence-based' treatment approaches may be compromised.⁴³

If a process of the scope of trauma-informed care and practice is to be realised in practice, reformulation of existing approaches to service provision is required (i.e. understandings which are adequate to the scope of the goal being proposed). The required shifts in service culture raise conceptual and practical challenges. But emerging research indicates how these challenges can be addressed.

Outcomes from implementation of trauma-informed care and practice into services

The benefits of introducing and embedding trauma informed principles, practice, and policy have been substantiated in many US studies^{44 45} and pilot programs⁴⁶ which show a decrease in psychiatric symptoms and substance use. When services become trauma informed and clients have access to trauma-specific services, outcomes are beneficial with improvement in their daily functioning and a decrease not only in trauma symptoms but also substance abuse and mental health symptoms.⁴⁷

Some studies also suggest that introduction and embedding of trauma informed practice may positively impact housing stability,⁴⁸ as well as a

⁴³ Jennings, A. (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services, *ibid*, citing Saakvitne, 2000; Harris & Fallot (2001), p.15.

⁴⁴ J.J. Cocozza, E.W. Jackson, K. Hennigan Outcomes for women with co-occurring disorders and trauma: Program-level effects. *J Subst Abuse Treat* 2005; 28: 109-19.

⁴⁵ Morrissey JP, Ellis AR, Gatz M. Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *J Subst Abuse Treat* 2005; 28: 121-33

⁴⁶ Kammerer N. Project RISE evaluation report. Unpublished program evaluation report. Boston, MA: Health and Addictions Research, Inc. and Health Institute for Recovery n.d..

⁴⁷ Morrissey JP, Jackson EW, Ellis AR. Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatr Serv* 2005; 56: 1213-22

⁴⁸ Rog DJ, Holupka CS, McCombston KL. Implementation of the Homeless Families Program.1. Service Models and Preliminary Outcomes. *Am J Orthopsychiatry* 1995; 65: 502-13.



decrease in hospitalisation and crisis intervention.⁴⁹ Within the homelessness sector, qualitative studies reflecting feedback from service providers report not only enhanced collaboration with clients but gains in terms of skills and agency. Supervisors in turn report greater collaboration both within their service and with outside agencies, with gains in staff morale and service effectiveness.⁵⁰

Qualitative feedback from a pivotal study, the DC Trauma Collaboration Study, has also reported that consumers have an enhanced sense of safety, collaborate better, have a greater voice, and were very satisfied with trauma-informed changes in service delivery overall.⁵¹ Because trauma-informed services lead to improved outcomes and do not cost more than non-trauma-informed services, they are also known to be cost-effective.⁵²

Recommendation 4:

All health, legal, justice, psychosocial and other services (i.e. all human service settings) accessed by survivors should be trauma-informed

B. Principles for counselling and psychological care

Consistent with the above, the principles on which effective psychological services associated with the redress scheme are based need to be *the principles of trauma-informed practice*. In this context, while the principles outlined in the redress report (reproduced below) comprise a valuable starting point, they require important and explicit supplementation in order to comply with the more specific and far-reaching principles of the trauma-informed paradigm.

Many models, therapeutic approaches and techniques are used by health professionals who work with survivors of child sexual abuse. Clients present for treatment at different stages of recovery, with variable symptomatology,

⁴⁹ Community Connections. Trauma and abuse in the lives of homeless men and women. Online PowerPoint presentation. Washington, DC2002. Available from: http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

⁵⁰ Community Connections, *ibid*.

⁵¹ Community Connections. Final report: Trauma-informed pilot project at the Rumford (Maine) unit of tri-county mental health services 2003.

⁵² Domino ME, Morrissey JP, Chung S, Huntington N, Larson MJ, Russell LA. Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatr Serv* 2005; 56: 1223-32.



coping and functionality. Many approaches are integrative or eclectic and demonstrate responses to individual client needs during the healing process.⁵³ Yet research undertaken by ASCA (documented in its nationally and internationally endorsed Guidelines) establishes that *irrespective of the particular modality or approach used, core features need to be present for therapy for complex trauma-related issues to be effective.*

In its *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* ASCA presents the core principles for clinical practice related to complex trauma, including child sexual abuse clients.⁵⁴ These are included for reference in Appendix 2.

Principles for counselling and psychological care currently listed in the RC Consultation Paper – together with comment on areas in which they need to be further refined to accord with the principles of trauma-informed practice – and clinical expertise in supporting the needs of adult survivors of complex trauma are as follows:

Currently listed principle: *Counselling should be available throughout a survivor's life*

Recommendation 5: Revised principle:

Trauma-informed counselling by practitioners educated and trained in service responses to clients who experience complex trauma-related issues should be available throughout a survivor's life

To the extent that the field/s of counselling and psychotherapy are yet to be trauma-informed (i.e. as distinct from increased recognition of the need for this, as per above comments) explicit reference to the need for life-long availability of *trauma-informed* counselling is necessary.

This is not a mere semantic addition. In light of the current absence of systematic introduction and implementation of trauma-informed principles

⁵³ Mental Health Coordinating Council 'Reframing Responses' Literature Review August 2006

⁵⁴ 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.



across the counselling field – and current lack of guarantee of the extent to which this will change in the future – it cannot be assumed that even life-long and easily accessible counselling will effectively assist survivors of institutional abuse as the Consultation paper clearly hopes will occur.

ASCA and other research substantiates the confronting finding that many survivors have been retraumatised by the very services they have accessed for support.⁵⁵ This includes within counselling sessions conducted by therapists who have insufficient knowledge of the neurobiological impacts of complex childhood trauma and abuse.

Notwithstanding a degree of overlap between widely known and adhered to counselling principles (i.e. irrespective of the particular modality deployed) and *trauma-informed* counselling principles (there is no single trauma therapy and all therapy needs to be tailored) trauma-informed counselling differs in significant ways from generalist and even specific and sophisticated therapeutic approaches which are not trauma-informed. ASCA is currently working on projects and programs both for therapists and clinical supervisors which help disseminate this important new knowledge. When applied to clinical practice across disciplines and approaches, it will substantially increase the effectiveness of psychological services to survivors.

Even at the semantic level alone, however, it is important that all reference to and recommendations for counselling of survivors should be paired with the descriptor of 'trauma informed'. This contributes to the discourse shift which needs to occur if trauma-informed practice is to be comprehensively introduced, embedded and normalised within all psychological (and other) services which effectively serve the needs of survivors.

Currently listed principle: *Counselling should be available on an episodic basis*

⁵⁵ Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. New York: Oxford University Press.

Jennings, A. (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. United States: 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).

Davidson, J. (1997) *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions*. NSW Department for Women and the NSW Health Department



Recommendation 6: Revised principle:

Trauma-informed counselling by practitioners educated and trained in service responses to clients who experience complex trauma-related issues should be available on an episodic basis

As per above

Currently listed principle: *Survivors should be allowed flexibility and choice*

Recommendation 7: Revised principle:

Survivors should be allowed flexibility and choice which accommodates vulnerabilities, as well as strengths, and respect for diverse coping mechanisms according to trauma-informed principles

While the offering of choice/s to survivors is critical (and one of the foundational principles of trauma-informed practice) what this actually entails also needs to be considered in more detail than may initially appear. Allowing 'flexibility' also serves to illustrate the point. Degrees of perceptual rigidity are a frequent legacy of complex trauma, such that the assumption of survivors' immediate capacity to respond to the possibility of choice (i.e. with which they may have limited experience following a prior history of its withholding and violation in the context of interpersonal and institutional betrayal) may impede their ability to respond to it.

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'.⁵⁶ (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 and experiences. Depending on the point at which they engage in counselling,

⁵⁶ 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.



these may be quite unfamiliar. In this context, a helpful distinction is drawn by one clinician between the complex trauma client as expert on 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.⁵⁷

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, as may be the case for clients who have not been subject to the neurological disruptions of early life trauma. For this reason, the trauma-informed principle of respect for vulnerabilities and diverse coping mechanisms (which is not inconsistent with an orientation which is simultaneously strengths-based) should correspondingly be a guiding principle when introducing and offering choice/s to survivors.

Informed choice should also be available to survivors with respect to the therapist or service they consult. For example ASCA has a database of health professionals and agencies which specialise in working with clients with complex trauma-related issues which are the legacy of childhood trauma and abuse. Entry onto this database necessitates applications which include referees and which attest to expertise and experience in supporting survivors.

Subject to practitioner availability in or near their geographical area, callers to the ASCA 1300 Professional Support line can access referrals to face-to-face therapeutic support with practitioners conversant with the challenges they face. Where possible, more than one such referral is offered.

Recommendation 8:

Choice of practitioner and service should comprise a principle of counselling and psychological services offered by the redress scheme and this should include mechanisms to enable it. Ideally this would be subject to an accreditation process with agreed minimum standards and ongoing quality assurance processes.

⁵⁷ Gold, *ibid.*



ASCA's role in maintaining, managing and expanding such a database is recommended. This would utilise agreed guidelines established through broad consultation, and build on an existing efficacious service model, expertise and experience.

Currently listed principle: *No fixed limits on services provided to a survivor*

Recommendation 9: Revised principle:

No fixed limits on trauma-informed services available to survivors.

This would necessitate introduction/implementation of a mechanism which ensures that services offered and accessed continue to be trauma informed and delivered by practitioners educated and trained in service responses to clients who experience complex trauma-related issues *

It is important to acknowledge that it is inappropriate to engage with an adult survivor of institutional child sexual abuse in the absence of ability to offer them the long term support they may need. This is also because lack of follow-through could be perceived as 'another' rejection or result in feelings of abandonment. As trustworthiness is a core principle of trauma-informed practice, it is essential that survivors can be assured of availability of expert psychological support at any point they may need it in the future. It is likewise essential that availability of such services, within an acceptable timeframe is guaranteed.

*Also see 'Accreditation and training' and below principle

Currently listed principle: *Psychological care should be provided by practitioners with the relational capacity and skill set to work with complex trauma clients*

Recommendation 10: Revised principle:

Psychological and counselling care should be provided by practitioners with the knowledge and skill-base to work safely and effectively with complex trauma clients via accreditation of practitioners to ensure this capacity*



*Also see 'Accreditation and Training'

Currently listed principle: *Suitable ongoing assessment and review*

Recommendation 11: Revised principle:

Suitable ongoing assessment, monitoring and review of all psychological and counselling services delivered to survivors. All services should adhere to the principles of trauma-informed practice (see ASCA Practice Guidelines part 2), the methodology of 'practice-based' evidence and meet accreditation standards.

'Practice-based evidence' inverts and is an alternative to the paradigm of 'evidence based' (the latter of which refers to the description and endorsement of treatments and therapies which have undergone scientific testing and research). While seemingly unexceptionable, the requirement that treatments be 'evidence-based' is problematic in a number of respects (for example in privileging a scientific paradigm the applicability of which is not questioned).⁵⁸

Absence or paucity of research into a particular treatment does not of itself mean that a particular therapy 'doesn't work' (e.g. research in relation to it may not have been carried out). This is an important point to underline in a culture in which 'lack of evidence' (which routinely equates to *scientific* evidence) can wrongly imply a treatment approach to be ineffective. By contrast, 'practice-based evidence' suggests a different reading of what 'evidence' comprises.

In contrast to 'evidence-based practice', 'practice-based evidence' gauges treatment effectiveness with reference to *client feedback* which in turn guides the treatment.⁵⁹ Correspondingly, it recognises the input of the clinician (who might otherwise be remote from a research culture) to the particular therapies being applied. Practice-based evidence is also underpinned by belief that the most valuable measure of treatment effectiveness is client *outcomes* (on which

⁵⁸ Also see subsequent discussion in 'Models for implementation of the redress scheme'; 1. Reconceptualisation/overhaul of *Better Access*.

⁵⁹ Duncan, B., Miller, S. & Wampold, B. & Hubble, M., eds. (2010) *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd edit. Washington, DC: American Psychological Association.



there is comparatively much less emphasis when evidence-based practice is regarded as definitive).

The requisite for all treatments to be 'evidence-based' is ill-advised and unrealistic. This in light of both the many problems associated with this requisite, and its more specific limitations in the context of complex childhood trauma. For example, restricted entry criteria often preclude people who experience complex trauma from participation in trauma method outcome studies (Rothschild, 2011). Calls for practice and care which is 'trauma-informed' also highlight the limits of the imprimatur of 'evidence-based' as a necessary and sufficient measure of treatment effectiveness: '*Without such a shift [towards trauma-informed care]...even the most 'evidence-based' treatment approaches may be compromised*'.⁶⁰

Currently listed principle: *Services for family members if necessary for survivor's treatment*

Recommendation 12: Revised principle:

Trauma-informed services should be accessible and available for all family members and partners who wish to access it.

Principles of access to family members and partners and loved ones should:

- *Embody physical and geographic access (including meeting the needs of those in rural, regional and remote areas);*
- *Engender culturally appropriate responses.*
- *Remove any financial barriers*
- *Address psychological barriers associated with stigma, taboo, values and/or philosophy*
- *Non time-limited and permanently available*

Specific reference to, and requirement that, any service for family members of survivors should likewise be trauma-informed is advised (as per the other principles). It is essential that any and all services which can support family members and friends of survivors is organised around and reflects the

⁶⁰ Jennings, *ibid*, p.15 (emphasis added).



principles of trauma-informed practice (and thus complements the psychological services accessed by survivors). Failure to ensure this, and the ensuing complementarity, would negatively impact the effects of any such service for family members of survivors, and thus indirectly impact in a negative way the benefits to survivors.

Supporting an adult who experiences the effects of childhood trauma is challenging as well as rewarding. A 'trauma informed' approach to interpersonal relating to them can make many positive differences. A trauma-informed approach minimises the potential for upsetting and destabilising interactions. It rests on awareness of the impacts of trauma, and recognises that many problems faced by survivors are trauma-related. It thus understands the links between 'past' traumatic experience and current challenges of everyday life.

Family members, friends, loved ones and partners, typically receive little support, and can feel they are 'struggling alone'. This is why an approach which is 'trauma-informed' is very valuable.

C. Principles for supporting counselling and psychological care through redress

Access to counselling and psychological services

The requirement for psychological services to be permanently available to survivors who have experienced institutional abuse is not the same as continuous accessing of them. Frequency of contact with psychological services (which may also differ according to the nature and mode of their delivery) will depend upon the needs and wishes of survivors themselves. These may be very contrasting depending on situation, personality, life challenges of the time, and a range of other factors.

Care should be taken that survivors are not regarded as a homogenous group. This is even when they may share particular features and experiences (in the case of those accessing support under the redress scheme an obvious common feature would be the institutional context of abuse). Best practice treatment for complex trauma is also phased treatment. It is important to note that



survivors will also be at different points in the addressing/resolution of their trauma according to their prior experiences (both of life and of therapy).

Availability of services which are non-time limited also requires consideration of other factors. These include the ongoing progress of clients, opportunities for empowerment and growth beyond a particular therapeutic process, and the capacity for therapists and services to see new clients while also seeking to meet the longer term needs of other clients. For longer-term clients, consideration should also be given to the possibility of 'staggering' appointments (i.e. intervals of time between them) or to a group maintenance process. (also see 'Duration of therapy' below).

Recommendation 13:

Psychological services should be permanently available and accessible and determined by survivor choice and need (as distinct from permanently or continuously accessed).

Recommendation 14:

Provision of counselling and psychological services by survivors under the redress scheme needs to be timely and responsive at the point at which it is sought.

Frequency of uptake will depend on a range of factors particular to the individual survivor and context. These cannot be generalised or determined in advance. What is important is that psychological services offered under the redress scheme are known by survivors to be 'always there' at any time of survivor choice and need.

Delivery modes

In addition to expanded specialist face-to-face and telephone counselling services, educational workshops and online support should be utilised as a key component of available psychological services. A significant proportion of survivors of institutional abuse may be reluctant to access face-to-face and even telephone counselling (i.e. irrespective of their specific location). Provision of knowledge, information and tools from educational workshops as



well as '24/7' availability of an anonymous service whereby they can log in online to access support could be very effective modes of service-delivery. Of course this also

presupposes consistent availability of appropriately trained staff, adequate provision for 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 (where the latter clearly need to comply with best practice in relation to group work for survivors who experience complex trauma-related issues).

Recommendation 15:

Counselling and psychological services available to survivors via the redress scheme should be diverse and comprehensive. They should be accessible via as many modes as can be quality assured in a trauma informed manner.

In addition to face-to-face (individual) counselling and psychotherapy, a range of other specialist services are outlined here below, all of which must always 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
- 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.



- Central registry/referral database managed by 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
- 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 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, shame, and promote peer networks of support.
- 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
- 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; also see 'Duration and frequency of sessions' below).
- Trauma informed inpatient programs which are an adjunct to therapy, minimising the risk of re-traumatisation but 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 will help supporters learn to use a trauma-informed approach to interpersonal communication and relationships. It could 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.
- Parenting services and resources to help break the cycle of abuse and trauma. Existing parenting programs while effective in mainstream populations are inadequate as they do not address the specific wounds and issues of child abuse survivors who become parents.

Key areas for attention in delivery of counselling and psychological services* (*i.e. additional to the foundation of trauma-informed and to previously noted)

- **Collaborative care where necessary and appropriate**

Consistent with recognition that survivors may have contact with diverse health professionals, is that psychological services available under the redress scheme need to be able to facilitate 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.

Recommendation 16:

Coordination across service responses (including between practitioners, sectors, systems, crisis and counselling and psychological services), enhanced communication (including greater capacity for warm transfer, better intake and risk assessment in therapeutic services) and greater capacity for different components of care to cross refer and communicate, including pre and post discharge

- **Continuity of care**

Lack of continuity of care is highly disruptive to the many survivors who require it. The existing 'merry go round' of unintegrated services impedes the effectiveness of particular treatments/therapies if survivors are unable to experience follow up in a timely and convenient manner.

Recommendation 17:

In combination with the need for collaborative care (as above) optimal delivery of psychological services should also be predicated on the principle of continuity of care.

- **Duration and frequency of sessions (individual counselling/psychotherapy)**

Delivery of effective psychological services to survivors of institutional abuse needs to be predicated on the principle (upheld by clinical research) that complex trauma treatment is generally longer than that for other presentations. While varying significantly according to the client, it is 'rarely...meaningful if completed in less than 10-20 sessions'⁶¹

⁶¹ Courtois, C.A., Ford, J.D., & Cloitre, M. 'Best Practices in Psychotherapy for Adults', in Courtois & Ford, ed. (2009) *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. New York: The Guilford Press, p. 96.



The rationale for generally longer treatment duration of complex trauma than that for other presentations is also based on expert consensus recommendations for treatment in this area. The extensiveness of the impacts associated with complex trauma means that *three phases* of treatment are recommended:

- (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.⁶²

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.⁶³

⁶² ISTSS Expert Consensus Guidelines for Complex PTSD November 2012 pp 5-6.

⁶³ 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.psychiatrictimes.com/print/201>⁶³ Rothschild, B. (2011) *Trauma Essentials*. New York: Norton, 57; Courtois, Ford & Cloitre, *ibid*, p.98.



Therapists also need to be aware of differences in client capacity to engage in therapy and to resolve their symptoms and distress. ('There are as many degrees of self- and relational impairment as there are of healing capacities and resources, resulting in different degrees and types of resolution and recovery' *ibid*: 98). But the principle that effective therapy for childhood trauma is not achievable within 6-8 sessions (much less 1-2) needs to be acknowledged at the outset, and the nature and provision of psychological services structured accordingly.

Where survivors themselves may be unable or unwilling to engage in therapy to this extent, there are strong grounds to confine the focus of therapeutic work to the 'Phase 1' (stabilisation) stage ('Overstatement of the importance of this step is not possible; it is vital if trauma recovery is to be realised').⁶⁴ ;

The extensive neurobiological impairments with which complex childhood trauma is associated accounts for the increased number of therapy sessions which is generally required. It also underlines the importance of widespread knowledge – both within the mental health sector and the general community – 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).

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').⁶⁵

Exceeding these recommended standards of frequency in the absence of compelling grounds for doing so, needs to carefully consider the risks of destabilisation and dependence.

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-

⁶⁵ Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', *ibid*, pp. 96-7.



understanding, and reduction of isolation, shame and related cognitive distortions.

Recommendation 18:

While the variations between individuals, contexts and life circumstances necessarily mean that the precise number and frequency of required face-to-face individual sessions cannot and should not be mandated in advance, the need for generally longer treatment duration of complex trauma and sessions of greater frequency than that for other presentations should be acknowledged, noted and accommodated.

- **Engagement of survivors**

The longstanding lack of psychological services appropriate to the needs of survivors means that careful thought, effort and planning needs to be undertaken to engage the many people who are eligible to access counselling and psychological services provided as a result of the redress scheme. To the extent that many survivors have had either no prior experience of accessing psychological support or have been retraumatised in so doing, it cannot be assumed that all those of this cohort who would benefit from it will necessarily embrace the prospect of accessing psychological services, however well – designed and structured).

Recommendation 19:

A concerted and sensitive communication strategy to enhance publicity and engagement around counselling and psychological services provided as a result of the redress scheme needs to be carefully designed and comprehensively implemented.

Clearly it would be a travesty if, as appropriate services belatedly became available, some survivors failed to access them because they had not been appropriately engaged, informed and encouraged to do so. Promotion of the possibility of choice of practitioner or service (e.g. via referrals from a purpose-built database on which appropriately qualified trauma informed therapists are registered as per an expanded database of the kind currently administered by ASCA) should comprise part of the necessary engagement.



- **Attentiveness to diversity**

Diversity comes in many forms. For example, a trauma-informed perspective mandates respect for diverse coping strategies as well as the more familiar social markers of age, ethnicity, gender, socio-economic status, etc (Fallot & Harris, 2009; Jennings, 2004). This also illustrates another of the many and significant differences that a trauma-informed awareness entails. To optimise their therapeutic benefits, psychological services offered under the redress scheme will need to be maximally attuned to the myriad expressions of diversity among a diverse client base, and sensitively attuned to their potential dynamics and impacts.

Recommendation 20:

Principles of access to all adult survivors of complex trauma should:

- ***Ensure physical and geographic access (including meeting the needs of those in rural, regional and remote areas); as well as***
- ***Engender culturally appropriate responses.***
- ***Remove any financial barriers***
- ***Address any attitudinal barriers (e.g. which may stem from different world views and value systems) which could serve to limit uptake of services by all sections of the community***

Accreditation and Training

Survivors of institutional abuse seeking to access psychological support via the redress scheme will benefit from contact with diverse health professionals. The prevalence of complex interpersonally generated trauma within the community more broadly also means that adults with trauma-related health issues 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'.⁶⁶ But it is essential that diverse staff and support workers, clinical and non-clinical, are available and appropriately skilled to meet the needs of these client populations. Equally clear is the need for training pathways and accreditation by which diverse practitioners can acquire the appropriate skills, and mechanisms by which they can be quality assured on an ongoing basis.

The nationally and internationally endorsed ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery (2012) are addressed to a diverse array of health professionals; ASCA offers many trainings in this area.

Recommendation 21:

Co-ordination of training for the diverse allied health professionals who will work clinically with adult survivors associated with the redress scheme, and which for health practitioners already working in therapeutic contexts with survivors might take the form of a supplementation/consolidation course.

Recommendation 22:

Introduction of mandated trauma-informed training which is nation-wide for generalist services to provide a dedicated pathway to acquisition of the various competencies necessary for provision of effective non- traumatising psychological services to survivors.

Recommendation 23:

Establishment of an accreditation body which can coordinate, monitor and quality assure the training and professional development of the diverse health professionals needed to provide trauma-informed psychological services to survivors.

D. Options for service provision and funding

⁶⁶ King, R. (2013) 'Psychological services under Medicare: Broken but not beyond repair'. *Psychotherapy in Australia* (Vol.19, No.2), p.41 (emphasis added).



1. Reconceptualisation/overhaul of *Better Access*

In 2013 Professor Robert King of the School of Psychology and Counselling, QUT, presented a wide-ranging critique of the *Better Access* program of the Medicare Benefits Scheme.⁶⁷ The *Better Access* scheme ostensibly provides effective and affordable psychological services to the Australian public. But it is seriously deficient in major respects. Professor King identified a number of weaknesses of the current scheme and proposed alternative measures to address them.

Formulation of the redress scheme for survivors of child sexual abuse in Australian institutions presents a striking opportunity to simultaneously address the current disabling deficiencies of the *Better Access* scheme in ways which could have far-reaching benefits both for survivors of institutional abuse and the broader Australian public. As ASCA research substantiates, these groupings intersect in ways which are insufficiently recognised.

The *Better Access* program is not currently well placed to service survivors. But it could be reformulated in targeted ways which would potentially allow it to do so, and which would concurrently enhance accessibility and affordability of psychological services for the wider Australian public (a high proportion of which, as the recently released ASCA report *The Cost of Unresolved Childhood Trauma and Abuse in Australia* substantiates, likewise experience complex trauma-related problems).

Care would clearly need to be exercised to ensure that the specific needs of survivors are not subsumed within the psychological needs of the Australian public more broadly. But it is also the case that the convergence between them in key respects (i.e. the many adult health problems generated by complex childhood trauma when the underlying trauma is not resolved) is marked.

The redress scheme – of which a reformulated *Better Access* program could potentially comprise a core component – thus represents a golden opportunity both for survivors of institutional abuse whose specific psychological needs

⁶⁷ King, R. (2013) 'Psychological services under Medicare: Broken but not beyond repair'. *Psychotherapy in Australia* (Vol.19, No.2), pp.38-42.



have long gone unmet and overdue targeting of a public health problem (i.e. complex childhood trauma and its devastating impacts on adult health). It is striking that the flaws of the *Better Access* scheme identified by Professor King- and the benefits of the alternative measures he proposes – also converge not only with quality research in and of psychotherapy but with clinical and neuroscientific insights which directly relate to optimal treatment for resolution of trauma.

Specific and serious flaws of the *Better Access* program identified by Prof King include:

- **Radical and unwarranted restriction of the types of psychological treatment/therapy endorsed and for which remuneration is possible**
(*‘A distinctive feature of the psychological services (other than those provided by clinical psychologists) funded under Better Access is that they must be focused psychological strategies (FPSs)...Five such strategies are specified. All but one are components of Cognitive Behaviour Therapy (CBT)’.*⁶⁸
- **Unwarranted and ill-advised restriction of practitioners mandated to provide psychological services to the Australian public**
(*‘Most providers are psychologists, but some social workers, occupational therapists, mental health nurses, Aboriginal and Torres Strait Islander health workers can provide FPSs under Better Access’.*⁶⁹

In combination, these flawed criteria lead to the monopoly of a restricted and select group of practitioners who are mandated to offer a very limited range of treatment possibilities.⁷⁰ This is also at a time when the burden of need for psychological services is high and increasing.

In terms of the psychological needs of survivors, the effect is dire. This is because the prevalence of trauma remains unrecognised by government funders, and mandated services are not required to be trauma-informed. In short, not despite but *because* of the *Better Access* scheme, accessibility and

⁶⁸ King, *ibid.* p.38.

⁶⁹ *Ibid.*

⁷⁰ To the extent that no market mechanism is operative or competition allowed, Prof King refers to nothing less than ‘a North Korean approach to service provision’ (King, 2013: 39).



affordability of a wide range of psychological services is severely restricted both for the general public and for trauma survivors in particular.

Yet restriction of access to a range of health professionals and treatment types does not exhaust the problems of *Better Access* identified by Prof King (and others). Quality, too, is compromised. Fundamental problems characterise *Better Access* foundational assumptions regarding *evidence base* and *philosophical conception of patients/clients*.

As highlighted by Prof King, 'the core of the problem' in restricting rebates to 'a delimited set of specified interventions' (i.e. the FPSs) stems from a mode of thinking which has two serious effects. The first is compromise of the role of *clients as active agents in therapeutic change* (which simultaneously also violates a core trauma-informed principle). The second is absence of *an effective mechanism for quality assurance*.⁷¹ Both are problematic, and their combination, especially so.

Core principles of trauma-informed practice, which are critical for adult survivors, but also serve as a model for effective health service-provision more broadly - are *safety, trustworthiness, choice, collaboration* and *empowerment*.⁷² There are several senses in which the specification of treatment mandated by *Better Access* undermines these principles by 'treat[ing] the client as a passive recipient of an intervention prescribed by an expert therapist'.⁷³ This re-enacts a scenario in which survivors experience echoes of the disempowerment and withholding of choice which characterised their prior traumatic experiences.

The centrality of the client as an active participant in their own healing (rather than a passive recipient of professionally mandated treatment) is also at odds with the 'strengths based' and 'whole person' approach which characterises a wide range of therapeutic modalities unrecognised and unremunerated by the *Better Access* initiative.

⁷¹ Ibid.

⁷² FalLOT, R. & Harris, M. (2009) 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol'. Washington, DC: Community Connections; Jennings, *ibid*.

⁷³ King, *ibid*, p.38.



That quality of treatment is undermined – rather than enhanced – by *Better Access* foundational assumptions and mandating of a select group of practitioners and treatment type is a particularly disturbing aspect of Prof King’s critique. The claim that mandated treatments are ‘evidence based’ is often invoked to support exclusion of endorsement of other therapeutic modalities. Yet the implied and explicit claim that the quality of psychological services is enhanced by limiting the type and number of prescribed treatments- as well as the professions of the practitioners who can offer them- is revealed to be fallacious.

With respect to treatment type, cognitive behaviour therapy (CBT) is widely cited to be ‘evidence based’, which serves as justification for its dominance among the treatment modalities *Better Access* endorses and remunerates.⁷⁴ Yet Prof King is explicit that ‘not only is there an absence of evidence for superiority of CBT or any other brand, there is overwhelming evidence for brand equivalence’.⁷⁵ Indeed, ‘*[t]he evidence for treatment equivalence is now so overwhelming that even groups with vested interest in branded therapy have begun to acknowledge the futility of an approach to service delivery that relies on brands*’.⁷⁶

Based in part on the results of ‘common factors’ research,⁷⁷ consistent findings which show modality equivalence themselves comprise powerful ‘evidence’. But it is evidence of which the mantra of ‘evidence-based’ fails to take account. The only reason, King goes on to say, that failure to endorse

⁷⁴ ‘Through the 1970s and early 1980s a series of studies appeared apparently confirming the equivalent efficacies of cognitive and drug therapies and indeed pointing to a possible extra benefit of cognitive therapy in postponing or reducing the likelihood of relapse’ (Healy, 1999:239). As a widely promoted ‘evidence-based’ treatment, cognitive behavioural therapy is generally short-term, and its principles and techniques (which often relate to recognition and interception of negative thought patterns) are relatively easy to learn. The emphasis of CBT on cognition means that it is less suited, however, to the addressing of emotion and is inadequate as a ‘treatment of choice’ for adult survivors of childhood trauma and sexual abuse (for whom a more extended number of therapy sessions in the context of an explicitly relational approach is widely recommended). Current research also confirms the centrality of sensorimotor processes in the context of trauma which likewise indicates the limits of CBT in the absence of attentiveness to physicality and the body (van der Kolk, 2006).

⁷⁵ King, *ibid*, p.39.

⁷⁶ *Ibid*, p.40.

⁷⁷ ‘Common factors’ is a term which describes the now considerable body of research which shows that the particular type of psychotherapy is less significant to the effectiveness of the therapy than are other factors involved in the process (Duncan, Miller, Wampold & Hubble, 2010). In ‘common factors’ research, dimensions which pertain to the client and the quality of the therapeutic alliance are more reliable determinants of effective therapy than the approach or technique deployed. This is in stark contrast to so-called ‘evidence-based’ treatment and practice, according to which such dimensions are regarded as irrelevant to treatment effectiveness



psychological services in accordance with this finding is not 'a source of outrage within the professional community' is because of perceptions of what 'evidence' comprises and the interests that accrue to these (*'a generation of psychologists has been taught erroneously that evidence-based practice consists of empirically supported treatments which, for the most part, means CBT'*).⁷⁸

Just as the paradigm of trauma-informed practice both supplements and challenges traditional biomedical approaches, so the approach of 'practice-based evidence'⁷⁹ challenges the familiar but problematically limited standard of 'evidence-based'.⁸⁰ The contention of King is that payment of the therapist should be 'contingent upon client reports' rather than on adherence to restricted and predetermined treatment strategies.⁸¹ This is in direct contrast to the foundational assumption of *Better Access*, where the client is a passive recipient of expert professional treatments which are assessed to be effective in advance (i.e. independent of patient specifics, input, alliance with the practitioner, and other 'common factors' found to contribute to successful therapeutic outcomes). The suggestion that payment for treatment should be 'contingent upon client reports' is emblematic of practice-based evidence, in which client experience and feedback, is critical to assessment of treatment effectiveness. It is also consistent with the principles of trauma-informed practice.

Similarly, denial of endorsement of a range of diverse health professionals in favour of clinical psychologists and some selected others is no guarantor of quality either. As King likewise elaborates, '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'.⁸² This finding, too, has particular application to provision of

⁷⁸ King, *ibid*, p.40.

⁷⁹ I.e. an alternative to the paradigm of 'evidence-based practice' whereby, in contrast to the latter, treatment effectiveness is gauged with reference to client feedback which in turn guides the treatment (Miller, 2005). It also recognises the input of the clinician, who understandably is not necessarily engaged in research. As previously noted, practice-based evidence is also underpinned by belief that the most valuable measure of treatment effectiveness is client *outcomes* (on which there is comparatively much less emphasis when evidence-based practice is regarded as definitive).

⁸⁰ 'Evidence-based' refers to the description and endorsement of treatments and therapies which have undergone scientific testing and research; see previous discussion for consideration of this standard which, while seemingly unexceptionable, is problematic in a number of ways.

⁸¹ King, *ibid*, p.41.

⁸² King, *ibid*; citing Montgomery et al (2010), p.41.



psychological services to adult survivors of childhood trauma, and to the large cohort of survivors of institutional abuse who will access these via the redress scheme.

The prevalence of complex interpersonally generated trauma means that adults with trauma-related health issues present to a wide range of services and practitioners. It is essential that diverse staff and support workers, clinical and non-clinical, are available and appropriately skilled to meet the needs of these client populations. The nationally and internationally endorsed ASCA *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (2012) are addressed to a diverse array of health professionals, and ASCA offers many trainings in this area. Exclusion of diverse health personnel from the *Better Access* scheme, and lack of subsidy of many of the effective modalities now available, makes neither economic nor ethical sense.

Reform of the *Better Access* scheme will require careful attunement to a number of variables (for example areas of deregulation in some respects and increased regulation in others).⁸³ But as King's critique and suggestions make clear, its current weaknesses serve neither patients nor many practitioners. A revised approach to *Better Access* could see it become an effective vehicle for delivery of psychological services to increased numbers of Australians in general and to adult survivors of childhood trauma in particular.

Recommendation 24:

Consideration should be given to ways in which the redress scheme for survivors of childhood institutional sexual abuse could be offered under the aegis of a reconceptualised Better Access program which is both trauma-informed and organised around recognition of trauma as a public health priority.

⁸³ Ibid.



DIRECT PERSONAL RESPONSE

'including the principles for an effective direct personal response and the interaction between a redress scheme and direct personal response' (p.14)

COMMUNICATION OF APOLOGY

Direct personal responses should comprise communications to each survivor which include the minimum requirements as per below.

[CAVEAT]

The way in which policies and recommendations are implemented (i.e. not just what these recommendations are) is a central principle of trauma-informed practice. For this reason, the following suggestions should not be detached from the manner of their delivery. To the extent that trauma-informed practice comprises a new paradigm with which many organisations involved in redress measures will be unfamiliar, it is essential that they receive appropriate training in this regard. ASCA stands ready to provide the necessary organisational training and ongoing support to organisations which will be necessary.

MINIMUM REQUIREMENTS OF ALL INSTITUTIONS FROM WHICH DIRECT PERSONAL RESPONSES MAY BE SOUGHT

[NB ASCA can assist with advice re wording and format in particular instances as it is important that the following are conveyed in an appropriate way]

(A) Apology

- Direct and unqualified apology to the survivor for the abuse to which they were subject while in the care of or otherwise connected to the institution. Where the specific perpetrator/s of such abuse are known they should be named.
- Direct acknowledgement of the harms caused by the abuse to which the survivor was subject, and direct expression of regret for both the abuse experienced and its subsequent impacts.



- Direct apology to the survivor that the abuse to which they were subject occurred within the context of and thus under the auspices of the institution. It should be clearly conveyed that this apology applies irrespective of any and all contingencies (e.g. the values and social attitudes of the time, whether the specific perpetrator/s are known, whether or not the institution was aware that the abuse took place, and irrespective of legal issues/implications).

(B) 2: Opportunity to meet with a senior representative of the institution

- Immediately following the apologies (min requirement 1 as above) an opportunity should be extended to the survivor to meet with a senior representative of the institution 'if [you] so wish'. The latter wording is important and should be included in the sentence in which this invitation is extended. As far as possible the date, time and location of any such meeting should be at the discretion of the survivor.

(C) 3: Assurance that steps are being taken to protect against abuse in the future

Broad information as to the nature of such steps should be included. This is because in the absence of such information the assurance could appear as mere rhetoric. Reference to specific measures will also serve as affirmation, record, and thus partial safeguard of their introduction and implementation for the institutions themselves.

Detailed enumeration of such measures should, however, be avoided in the communication of apology. This is because fine grained description of procedural mechanisms could overshadow and dilute the direct apology to the survivor and the acknowledgment of the harm they have suffered as an individual. The communication as a whole should be succinct; survivors can be advised of how they can access further details of measures to protect children from potential abuse.

RECOMMENDATION for a fourth minimum additional requirement



(D) 4: Expressed receptivity to any comment the survivor may wish to make

The communication of apology could/should conclude on a note of receptivity to any comment the survivor may care to make on receipt of it. In deference to the long legacy of childhood trauma – which cannot be excised by mere words and which is not ‘done and dusted’ by even the most empathically worded apology - it is potentially important to end the communication of apology on a more open-ended note. The following wording is one suggestion of how this might be expressed:

‘xxx [name of institution] will respectfully receive any response you care to make to this apology, irrespective of whether or not you choose to meet with a senior staff representative’.

INTERACTION BETWEEN A REDRESS SCHEME AND DIRECT PERSONAL RESPONSE

Both individual notification and broad publicity should be instigated to ensure survivors are aware of both these dimensions and what they entail. As the interaction between them may be challenging for many survivors, an intermediary body should be available to provide advice, support and to facilitate contact where necessary.

The organisation Adults Surviving Child Abuse (ASCA) is well placed to act in this capacity. As ASCA provides training in trauma-informed practice, supervision and consultancy to organisations and institutions (i.e. in addition to direct support to survivors) it would be well able to support all parties involved and to liaise effectively between them.



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Appendix A

Recommendations from the ASCA/Pegasus Economics document: *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia (2015)*

1. Active investment in specialist services

Specialist services are needed to spearhead policy and practice responses in relation to adult childhood trauma and abuse survivors. This requires active investment which supports a coordinated comprehensive model of care including continued and increased access to assistance and treatment through effective help lines and online services.

Timely active comprehensive intervention including appropriate support, counselling, resources and services promotes recovery. When survivors resolve childhood trauma they are freed to live productive, healthy and constructive lives, as are their children.

A key by-product of the resolving of childhood trauma for adult survivors is a financial benefit to Federal and State Government budgets. People affected by childhood trauma require significant costs on taxpayers. This is via higher Government expenditure on welfare support, health spending, criminal justice costs, and through lower taxation revenue.

2. More and better trained treating practitioners - counsellors/therapists

Unfortunately our public health system has evolved in a way which means that adult mental health services focus on addressing immediate health issues (such as depression and alcoholism) rather than identifying and addressing underlying causes (such as prior childhood trauma and abuse).

It is only through dealing with the root cause of problems that sustained inroads can be made in reducing system-wide health costs and helping adult survivors of childhood trauma and abuse to lead healthier lives in which they are also better able to contribute. Experience of childhood trauma and abuse is not a marker of intelligence or character. Nor is it a matter of exertion of 'will power' to simply 'move on' from it. Rather such trauma is associated with extensive neurobiological impairments.



These can be effectively addressed via appropriate treatment, services, and access to various types of resources and support. When survivors are receiving the right services and supports and the recovery process is underway, they can realise their enormous untapped potential. This is beneficial not only to survivors themselves, but to the whole of society.

Addressing only the later manifestations of prior childhood trauma and abuse is analogous to cutting the top off a garden weed. The visible sign of the weed is removed from sight for a period, but it will grow again. The only effective long-term solution to removing the weed is to extract the roots.

Similarly, in order to address many adverse behaviours in society, the underlying motivating issues must be addressed at the core. Childhood trauma is a key underlying problem that is often overlooked in health treatment services. ASCA has taken a leadership role in setting the standards for clinical practice in responding to childhood trauma and abuse and in building the capacity of the mental health workforce to improve health outcomes for adult survivors through training programs and other services.

Prior childhood trauma including abuse is not the only root cause of suboptimal health outcomes. But it is unquestionably a major one. Excitingly, it is also one which we now know can be addressed, and for which more healing can be achieved than previously thought possible. But this can only occur when it is appropriately addressed. Dealing with childhood trauma and abuse at its core - and with the complex needs of those affected by it - involves expert treatment interventions, often of an intensive nature. While for some people this will require an extended period of time, this will not be the case for others. There is no 'one size fits all'; appropriate responses also need to be tailored to the individual and attuned to gender, age, ethnicity and other forms of diversity.

Counsellors/therapists must be specifically trained to deal with the complexity of the issues involved. Counselling and therapy must also be accessible and affordable throughout the country. Widespread investment in training supported by a program to accredit practitioners of a range of disciplines is also recommended for consideration. Unless diverse practitioners are attuned to and skilled regarding the multiple and specific needs of adults who

experience the impacts of childhood trauma, further harm can be done. Sadly we know that re-traumatisation can occur within the very services accessed by adult survivors for support.⁸⁴). Hence the vital need for appropriate training and regulation of practitioners, and for all personnel who come into contact with survivors to operate in a trauma-informed manner.

3. A convenient and failsafe pathway to treatment – No wrong door

Frontline practitioners: General Practitioners and nurse practitioners will, on a daily basis, inevitably see people who have been impacted by childhood trauma ('every physician will see several patients with high ACE scores each day'.⁸⁵ Thus there are multiple and ongoing opportunities to facilitate a process whereby the presenting person can start receiving appropriate support. Such support may be direct or via targeted referral (including specialist counselling/therapy, ideally from an accredited practitioner).

Primary care practitioners need knowledge and skills to respond appropriately to patient disclosure of childhood trauma or abuse. They also need to be attuned to the possibility of such a history in the patients they see. This is because the topic may not be raised directly by patients themselves, and potential signs of it may continue to go unrecognised. In both cases a convenient yet failsafe referral network to appropriate assistance is required.

For example, if a GP recommends the survivor access ASCA's 1300 Professional Support Line and online services, they can be fully confident that the person will receive best-practice short-term counselling support and targeted referral. We encourage the Government to sustain and extend funding for this critical specialist health infrastructure. We also urge investment in the training of

⁸⁴ Jennings, A. (2004) 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'. United States: 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); Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. New York: Oxford University Press.

⁸⁵ Felitti VJ, Anda RF, '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. (2010) *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*. Cambridge: Cambridge University Press, pp.78.



front-line practitioners to enable them to support, respond, and refer as required.

4. System, service and institutional improvements - Trauma-informed practice

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. As the data attests, we are talking about large numbers of people. 'Individuals with histories of violence, abuse and neglect from childhood...make up the majority of clients served by public mental health and substance abuse service systems'.⁸⁶ The majority of people who access the mental health sector have undergone many overwhelming life experiences, interpersonal violence and adversity.⁸⁷

The capacity to meet this level of need requires restructuring of services to better accommodate people for whom the legacy of complex childhood trauma continues to impact their lives. ASCA's nationally and internationally recognised Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery include guidelines which establish the benefits of trauma-informed practice for diverse services. ASCA's training programs and other services help put this research into practice.

Essentially trauma-informed practice seeks to create environments and management practices that do no harm and which do not replicate the sorts of environments that gave cover to childhood abuse. The emphasis is on service cultures and delivery which are reassuring to survivors and which facilitate environments in which they do not feel that choice is being taken away from them. It is crucial that adult survivors of childhood trauma do not re-experience the sense of being trapped and disempowered, so often a feature of their early years, within service settings.

A key reason why childhood abuse is so damaging is that the normal responses to danger of 'fight or flight' are unavailable to children in abusive situations. Unable to flee, they often 'freeze'. This is another trauma response which accounts for the prevalence of dissociative responses in children. These

⁸⁶ Jennings, *ibid*, p.6.

⁸⁷ Bloom, *ibid*; Jennings, *ibid*.

responses need to be understood by the adults, including teachers and health professionals, on whom they are reliant.⁸⁸

Any replication of these sorts of environments for survivors of abuse risks further harm, compounding the problem, and high costs in all respects. ASCA's guidelines seek to minimise the probability of such outcomes. We recommend that all human service and health facilities implement the trauma-informed practice principles presented in the ASCA guidelines. This could be done via comprehensive training programs and systems review.

⁸⁸ Perry, B. D. & Szalavitz, M. (2006) *The Boy Who Was Raised as A Dog and Other Stories from a Child Psychiatrist's Notebook*. New York. Basic Books.



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*

- 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**

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