The Royal Australian & New Zealand College of Psychiatrists

Royal Commission into Institutional Responses to Child Sexual Abuse Issues Paper 10 'Advocacy and Support and Therapeutic Treatment Services'

November 2015

maximising opportunities for recovery

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Royal Australian and New Zealand College of Psychiatrists submission to the Royal Commission into Institutional Responses to Child Sexual Abuse

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 5,000 members, including around 3,700 fully qualified psychiatrists and almost 1,200 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey to recovery, including pharmacotherapy and psychotherapy.

Executive summary

The RANZCP commends the contribution of the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) to identifying how governments and institutions can prevent and alleviate the impact of past and future instances of child sexual abuse. The current consultation on ways of improving the accessibility of quality support services for victims and survivors is an important one, and we are pleased to have this opportunity to provide our input.

Psychiatrists, as medical doctors with advanced training in mental health, have a key leadership role in ensuring survivors and victims of child sexual abuse have access to a broad range of evidence-based therapeutic interventions. A holistic approach to treatment, incorporating psychological and pharmacological therapies, social supports and other approaches can make a real and lasting difference to the health and wellbeing of victims and survivors of child sexual abuse.

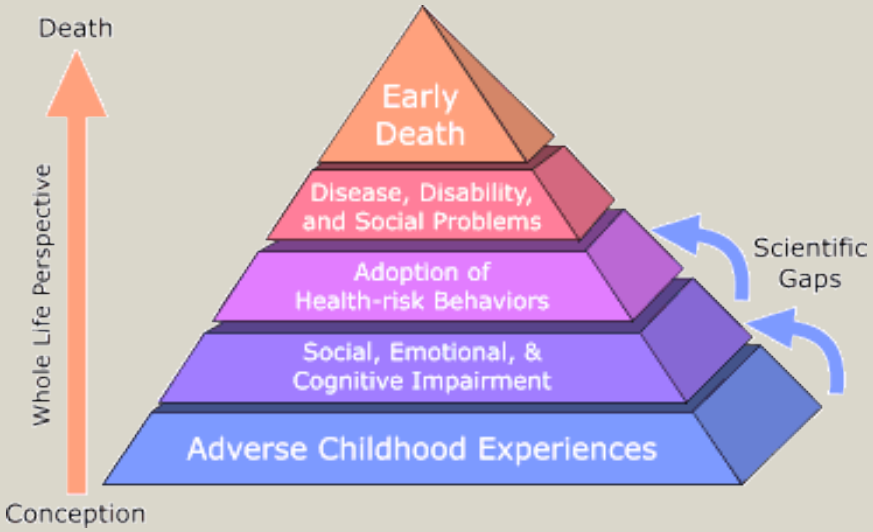
Key recommendations

- Therapeutic treatment for victims and survivors must take into account the particular aetiology of mental health issues linked to institutional child sexual abuse, as distinct from other experiences of trauma and mental health issues.
- A stepped approach to treatment and recovery is often necessary. The first step must always be to ensure the emotional and physical safety of the victim or survivor.
- Trauma-informed cognitive behaviour therapy and trauma-informed dialectical behavioural therapy have an evidence base for the treatment of survivors and victims of child sexual abuse.
- The recommendations made in the Royal Commission's *Redress and Civil Litigation Report* has the potential to greatly enhance access to appropriate therapeutic treatment. In particular we look forward to contributing to the development of a public register and enhancing the capacity of services to meet the mental health care needs of victims and survivors.
- We emphasise that the establishment of the public register must be accompanied by enhanced capacity for public mental health services to respond to the needs of victims and survivors of institutional child sexual abuse in a flexible, unlimited and trauma-informed manner.

Topic A: Victim and survivor needs and unmet needs

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

Adverse childhood experiences (ACE), such as sexual abuse, are known to be highly co-occurring and strongly associated with the onset of psychiatric disorders (Haliburn, 2014). Children exposed to trauma can develop behavioural difficulties associated with the unpredictability of their experiences, leading to a lack of verbal and conceptual understanding of their inner world and surroundings and how these two elements interact (Streeck-Fischer and Ven Der Kolk, 2000). ACEs can manifest in children and adolescents as conduct disorder, aggression, anxiety and mood disorders, hyperactivity, antisocial behavior, vulnerability to stress, difficulty regulating negative emotions, learning problems and oppositional behavior (RANZCP, 2014). If these issues are left unaddressed they can having lasting impacts on the mental health of the person, across their lifespan, as the diagram below illustrates.



(CDCP, 2014)

In treating victims and survivors of institutional child sexual abuse, sensitivity to the experience of chronic trauma is essential. Abuse may have been encountered from multiple sources, and over a period of time. For example, for those who experienced child sexual abuse in out of home care, experience of trauma may be protracted and from multiple sources, including the early home environment, and then in the institutional setting that they had been sent to for protection.

The sequele of this protracted experience of trauma is distinct from that of a survivor or victim of a single episode of abuse, for example. This should be reflected in treatment modalities.

Children and adolescents

Children and adolescents who have experienced institutional sexual abuse may not feel comfortable disclosing their experiences to a mental health professional straightaway. Clinicians may need to build trust over several sessions before the young person is ready to communicate openly. Children may express themselves in a diversity of manners, including through actions, play or drawings. Behavioural manifestations of trauma are also common. Medical practitioners must remain open to the child's preferred manner of expression and receptive to the meaning they are communicating.

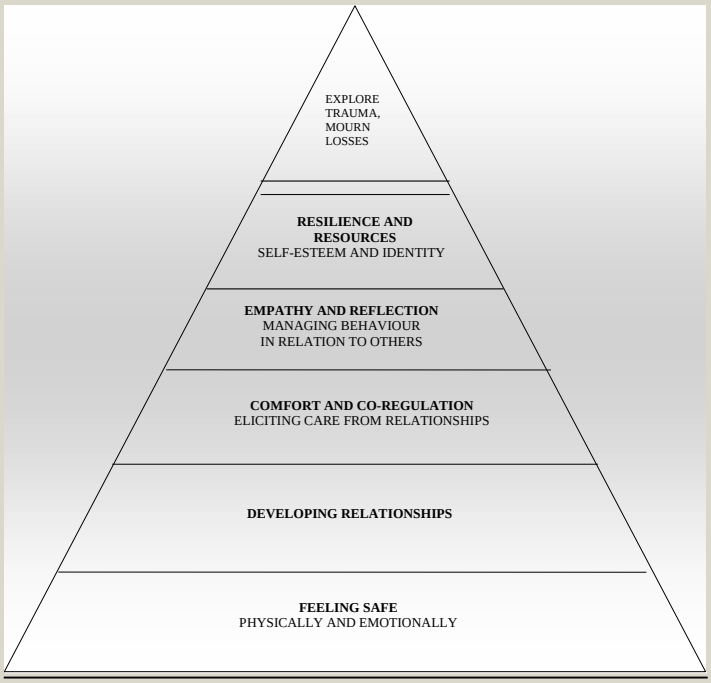
When sexual abuse has been detected, a stepped approach to treatment and recovery will often be necessary. The approach should be age-appropriate, culturally relevant and responsive to the unique

needs of the child or adolescent. Trauma-focussed cognitive behavioural therapy (CBT) has a strong evidence base for treating children as young as three years of age who have experienced abuse (Scheeringa et al, 2011).

A general guide to a stepped approach to treating children and adolescents who have experienced child sexual abuse is as follows:

- In the first instance the child's safety, both physical and emotional, must be established. Until external risks are addressed it will not be realistic to work on internal sources of danger, such as unmanageable impulses, fear and maladjusted defense mechanisms.
- Secondly, the child or adolescent needs to be supported to strengthen relational connections with people who can nurture them, and establish a safe and appropriate attachment relationship.
- Thirdly, support may be required around socialisation skills, developmental milestones and learning goals. Specialist services may be required to address specific areas of difficulty. At this stage of treatment, strategies that promote a return to normal development and engagement with age-appropriate activities may be required.
- Finally, once the child or adolescent has been supported to rebuild a sense of stability and safety, treatment can begin to address traumatic memories. It is crucial that the young person has first had the opportunity to build effective regulatory systems before treatment incorporates a direct focus on the trauma itself. If this has not occurred there is the risk that the trauma memory will be reinforced, rather than processed (ACF, 2013).

This stepped approach to addressing the needs of children and adolescents who have experienced sexual abuse is illustrated in the following diagram:



(Golding, 2007)

Evidence-based interventions, such as those described above, can be applied across the range of presentations, from early intervention with asymptomatic children exposed to recent abuse, through to more complex interventions in children with high levels of traumatic symptoms and dysfunctions in

complex parts of their life. This is important to note, as younger children may not yet understand the implications of their experience, and may appear less distressed than older children (WHO, 2003).

Adults

Adults who have experienced sexual abuse in childhood similarly require treatment that is trauma-informed and evidence-based. Adult victims and survivors require validation of their experiences and the effects of these, and the opportunity to discuss them openly with a person they trust and who will keep their disclosures confidential.

There may be feelings of shame or a sense of responsibility associated with the experience of abuse, and it is important that these issues are acknowledged and that responsibility is relocated to the perpetrator. Victims and survivors will often require support in addressing deeply rooted issues to do with self-worth.

Interventions may also be required to assist the victim or survivor to learn how to express anger in appropriate ways. Victims and survivors may have developed a range of maladaptive mechanisms for dealing with or avoiding their emotional distress, including substance misuse, self-harm or suicidal ideation. There are many therapeutic techniques used for teaching distress tolerance and addressing emotional dysregulation, including dialectical behaviour therapy (DBT), mindfulness, cognitive behaviour therapy (CBT) and acceptance and commitment therapy (ACT).

Adult victims and survivors of child sexual abuse who are severely affected may require support from a multidisciplinary team of mental health clinicians, including psychiatrists, psychologists, social workers and nurses. Brief admission to inpatient units may be indicated for some in periods of emotional crisis. Case management by a social worker for assistance with housing and employment may also be required for some people.

Recommendations

- Early identification of children experiencing sexual abuse is essential. Children may not disclose initially, and the clinicians should seek to build trust and be responsive to risk factors.
- Treatment must take into account the particular aetiology of mental health issues linked to institutional child sexual abuse, as distinct from other experiences of trauma and mental illness.
- A stepped approach to recovery for children and adolescents is often necessary. The first step must always be to secure the emotional and physical safety of the child, followed by support to establish safe and nurturing relationships, engaging with age-appropriate development activities and finally reprocessing traumatic memories.
- Evidence-based, trauma-informed interventions can be useful across a range of spectrums, from young children who present as asymptomatic to adolescents with complex behavioural issues. Trauma-informed CBT is of particular note, and has an evidence base for children as young as three years of age.
- Adults who have experienced child sexual abuse similarly require evidence-based, trauma-informed mental health supports in the context of a strong and trusted therapeutic alliance.
- DBT, mindfulness, CBT and ACT can be useful therapeutic techniques for working with adult survivors and victims.
- Adult survivors and victims who present with complex and severe mental health issues related to experience of trauma may require a multidisciplinary approach to support emotional and physical wellbeing, including assistance with housing, employment and other issues as necessary.

2. **What does not work or can make things worse or be harmful for victims and survivors? What do victims and survivors need but not receive?**

Attempts by institutions to avoid or deflect responsibility for the abuse that occurred are particularly harmful. Institutional acknowledgement of responsibility and sincere apology are necessary and, in contrast, adversarial or legalistic responses are inappropriate and alienating. Adequate financial compensation is necessary to enable victims and survivors to seek the assistance they need.

Recommendations

- The RANZCP supports the Royal Commission's work in ensuring that survivors and victims receive the recognition, apology and support they need.

3. **What helps or facilitates access so victims and survivors receive what they need? What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?**

The Commonwealth Department of Health's Access to Allied Psychological Services (ATAPS) and the Better Access initiative can link survivors and victims with evidence-based therapeutic interventions, led by specialist mental health services.

In the context of the Senate Community Affairs Legislation Committee's consideration of the Health Insurance Amendment (Safety Net) Bill 2015, the RANZCP has concerns that survivors and victims of child sexual abuse may face new barriers to accessing the therapeutic treatments they need, particularly intensive psychotherapy services. Given that the healthcare costs alone of unresolved childhood trauma in Australia are estimated at $9 billion (Kezelman et al, 2015) investment in ensuring survivors and victims of child sexual abuse have access to appropriate treatments offers significant long-term savings.

The RANZCP welcomes the Federal Government's acknowledgement in its response to the National Mental Health Commission Review of the need to support people with severe and complex mental illness to access the multidisciplinary supports they need (Department of Health, 2015). We look forward to working with the relevant stakeholders to implement this initiative, which has the potential to significantly help victims and survivors access the services they need.

Children and adolescents

For all survivors and victims of child sexual abuse, but in particular for young people who are more reliant on caregivers to facilitate engagement with supports, it is important that programs and services are accessible and coordinated. Where possible, services involved with the child, such as schools and mental health programs, should collaborate and collocate. In order to ensure this is feasible, child and adolescent mental health services (CAMHS) need to be resourced at a level that allows them to work flexibly and collaboratively with schools and other services, to share information, liaise with caregivers and school staff, and assist in making necessary adjustments at home, school or elsewhere as required.

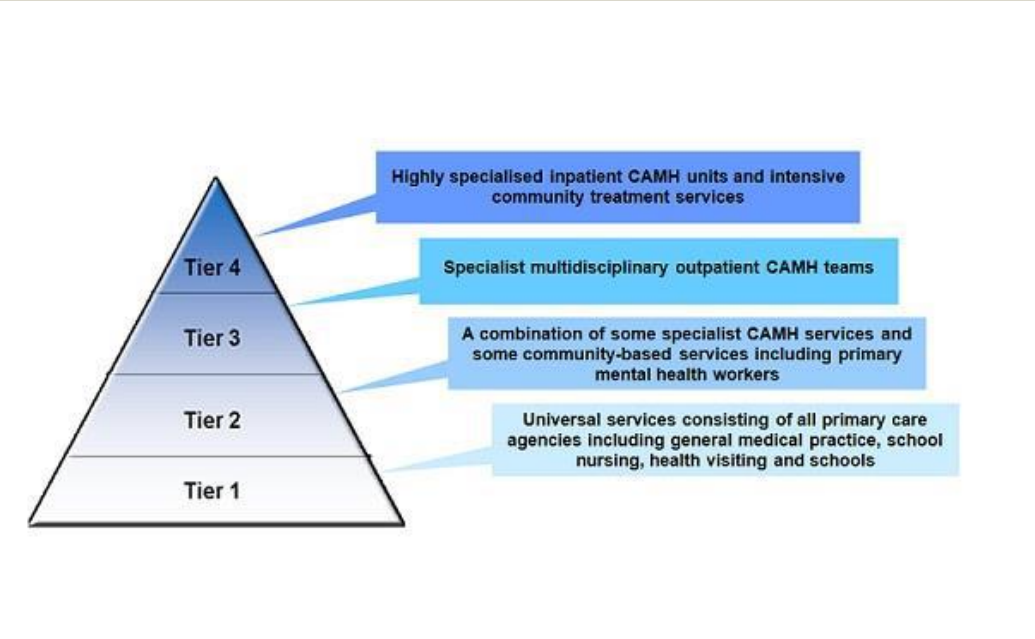
Communication between schools and CAMHS is also important for providing opportunities for professionals in both sectors to share their expertise. For child and adolescent psychiatrists, this may include providing training, support and consultation to school professionals, to assist them meeting the mental health needs of their students.

An example of an effective mechanism for enabling services to effectively wrap around the child or adolescent is the Evolve Interagency Service (EIS), an outcome of one of the recommendations of the

Commission of Inquiry into Abuse of Children in Queensland Institutions (the Forde Inquiry). The EIS was developed for children in care, however the model could be adapted for other contexts.

EIS provides therapeutic and behaviour support services that are responsive to emotional and behavioural problems (DCCSDS, 2015). A major goal of the EIS is improved collaboration between services. This has been facilitated by legislative change that allows for information sharing by 'prescribed entities', including all professionals involved in the care of the child. Sharing of information has been a crucial factor in the success of the EIS and has allowed for early identification of at-risk children by making it easier to connect relevant information, such as school absences and the onset of mental health issues.

For some children and adolescents, support and treatment from universal primary care services such as general practitioners and school programs may be appropriate to address the sequelae of trauma. However for others, their wellbeing and development may be more severely affected, and a combination of some CAHMS and some community-based services will be necessary. For children and adolescents who develop particularly acute mental ill health as a result of the trauma they have experienced, highly specialised inpatient units and intensive community treatment services led by specialist child and adolescent psychiatrists are necessary. This breakdown is illustrated below:



(NHS, 2015)

At present there is a general paucity of specialist services and professionals available to assess and treat more severe developmental issues in infants, children and adolescents, creating significant barriers to timely access to necessary supports. The Commonwealth Government's Specialist Training Program (STP) currently provides crucial funding for additional trainee positions in child and adolescent and perinatal and infant psychiatry, however funding for this important initiative has only been confirmed until February 2017.

Recommendations

- ATAPS and the Better Access initiative are supported by the RANZCP as effective mechanisms for ensuring victims and survivors can access the psychological supports they need.

- The *Fifth National Mental Health Plan* and reforms associated with the Mental Health Commission's *Review of Mental Health Programmes and Services* has the potential to facilitate survivors and victims of child sexual abuse to access the supports they need.
- The RANZCP is concerned that the proposed Health Insurance Amendment (Safety Net) Bill 2015 will restrict the availability of mental health care to vulnerable consumers, including survivors and victims of child sexual abuse, by making it prohibitively expensive to attend more than 50 sessions with a psychiatrist per year.
- CAMHS should be resourced at a level that allows flexibility and time to work with the young person, school staff, family and caregivers effectively and collaboratively.
- Adaptation of the EIS model for other contexts would allow important information to be shared across professions, aiding in the early identification of child sexual abuse, and enabling all relevant parties to have an awareness of important information about the child and their needs.
- More trainee positions in child and adolescent psychiatry are required to respond early and effectively to young survivors of child sexual abuse. Initiatives such as the Federal Government-funded STP play an essential role in this, and require ongoing funding.

4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors? How could these services be shaped so they better respond to secondary victims?

Secondary victims and survivors include close family members, especially children and partners, who may themselves have support needs related to the sometimes maladaptive behaviour, emotional turmoil or withdrawal of their loved one who has experienced abuse. There are currently no systemic ways of assessing and responding to secondary victims and survivors, who must therefore seek help as individuals.

For a parent, trauma, and particularly chronic unresolved trauma, can negatively impact on the formation of early attachment relationships with children, parenting capability and health family relationships overall. Disorganised attachment linked to unresolved parental trauma, particularly during the first three years of life, can disrupt the healthy development of rudimentary neuronal pathways, healthy psychological and relational development. It is essential therefore that, when adult victims and survivors of child sexual abuse present for mental health support, assessment includes identifying any children or adolescents in the person's care, and what support needs of secondary victims and survivors may have (RANZCP, 2009). Timely and adequate intervention for the victim and survivor, and their loved ones as necessary, is therefore required to prevent the cumulative and potentially intergenerational impact of trauma.

Recommendations

- When a victim or survivor of institutional child sexual abuse presents for assistance, enquiries should be made about the presence and welfare of any secondary victims or survivors, and referrals made as necessary.
- Particular emphasis should be placed on identifying and addressing the needs of young children of parents with chronic and unresolved trauma (Lieberman and Van Horn, 2008).

Topic B: Diverse victims and survivors

1. **What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups? What types of models and approaches are used to address the particular needs of these populations?**

Aboriginal and Torres Strait Islander peoples

It is essential that the mental health needs of Aboriginal and Torres Strait Islander peoples who have experienced sexual abuse are addressed in a manner that is culturally appropriate and sensitive to the interplay of compounding issues such as the Stolen Generations. Wherever possible and appropriate, treatment should incorporate the expertise of Aboriginal and Torres Strait Islander mental health workers, either in direct service provision or in a consultative capacity.

Recommendations

- Aboriginal and Torres Strait Islander mental health workers should be involved, either directly or in a consultative capacity, in the therapeutic treatment of Aboriginal and Torres Strait Islander survivors and victims of institutional child sexual abuse wherever possible and appropriate.
- Aboriginal and Torres Strait Islander mental health workers should be supported to fulfil this role, including via recognition within the team, salary and employment conditions at least commensurate with non-Indigenous healthcare providers, and additional supports as necessary (RANZCP, 2010).

2. **How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?**

Aboriginal and Torres Strait Islander peoples

The impacts of institutional child sexual abuse on Aboriginal and Torres Strait Islander peoples must be approached with care and cultural sensitivity. Aboriginal and Torres Strait Islander peoples may have experienced multiple layers of abuse, related to institutional child sexual abuse, the impacts of the Stolen Generations, discrimination and racism. Forced removal of children from their families and communities often placed young people at very high risk of institutional child sexual abuse, and has also contributed to the intergenerational trauma that Aboriginal and Torres Strait Islander peoples are continuing to grapple with.

This complex and interlinked set of factors can heighten vulnerability to the impacts of trauma and abuse. Historically negative experiences of social services, police and child protection also mean that Aboriginal and Torres Strait Islander peoples may face additional barriers to seeking assistance, in particular fear that disclosure may lead to family separation and other actions being taken without consultation.

Professional interpreters should be used if there is any doubt around the person's English skills, particularly capacity to describe complex or sensitive information about health and other issues. Family or friends should not be used as interpreters as this can lead to misunderstandings and breaches of privacy.

Recommendations

- Aboriginal and Torres Strait Islander peoples need to have ready access to culturally appropriate services, including interpreters when necessary.

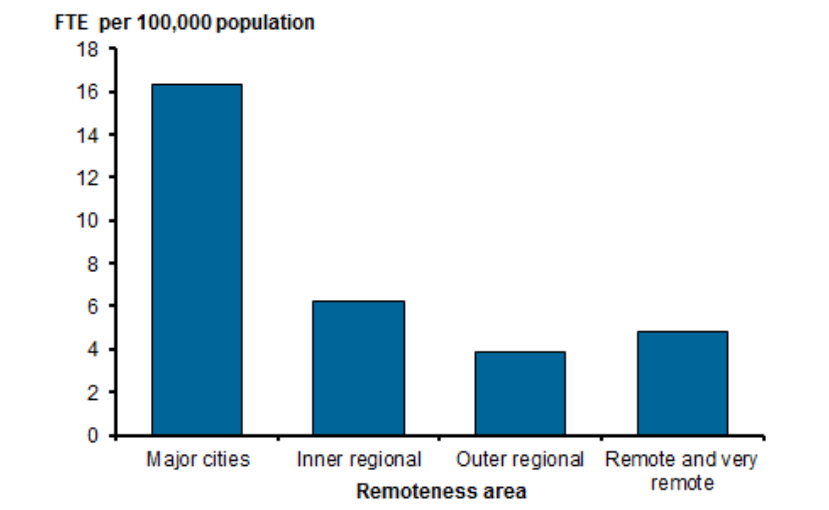
3. **What would better help victims and survivors in correctional institutions and upon release?**

The RANZCP has no response to this question.

Topic C: Geographic considerations

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

There is significant geographic maldistribution in all aspects of the medical workforce, with psychiatry particularly acute in this regard, as illustrated in the graph below, which depicts the number of full time equivalent psychiatrists by 100,000 population in Australia:



(Health Workforce Australia, 2012)

Rural and remote areas face an ongoing shortage of specialist mental health workers, particularly those practicing subspecialities. For child and adolescent survivors and victims of child sexual abuse living in rural and remote areas this often means significant barriers to accessing age-appropriate expertise.

The Federal Government-funded STP initiative discussed above also plays a crucial role in addressing this geographical maldistribution by supporting trainee positions in rural and remote areas. Funding for the STP is however only guaranteed until February 2017.

Recommendation

- Initiatives that support trainees to work in rural and remote areas, such as STP, are essential for ensuring the victims and survivors outside of metropolitan areas are able to access the support they require.

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

Innovative models of service delivery are required to meet the needs of rural communities and provide access to quality mental health care. This includes flexible models of psychiatric service provision such

as telepsychiatry and fly-in-fly-out services in communities that have inadequate numbers of resident or local psychiatrists or where subspecialists are unavailable.

The mental health workforce based in rural and remote areas require additional supports and incentives to improve the work sustainability and therefore workforce retention. This could include loading on Medicare Benefits Schedule (MBS) item numbers when the service is delivered in rural and remote areas. Financial assistance, support for family members to find work and settle in rural and remote areas and the availability of supervision via teleconferencing should also be considered.

Recommendations

- Innovative and flexible models of service provision should be supported to deliver services to victims and survivors of child sexual abuse in rural and remote areas. This includes telepsychiatry, fly-in fly-out services and financial incentives.
- Telepsychiatry in particular has the potential to deliver significant benefits to survivors and victims in rural and remote areas, especially in relation to subspecialist and consultation-liaison services (RANZCP, 2014).

Topic D: Service system issues

1. **There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?**

The RANZCP has no response to this question.

2. **Given the range of services victims and survivors might need and use, what practical and structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need? What type of service models help victims and survivors to receive the support they need?**

In general, public mental health services tend to focus on low prevalence psychiatric disorders and do not have the scope to provide the ongoing treatment often required to manage chronic, trauma-related conditions. Services are often under-resourced, and under significant pressure in responding to existing referrals. The public mental health sector therefore currently has limited capacity to respond holistically and appropriately to additional referrals of victims and survivors of institutional child sexual abuse. Further, the private health sector is only available to a relatively small percentage of victims and survivors who can afford outpatient treatment.

Nevertheless, the RANZCP believes that publically-funded service models are the most appropriate to help victims and survivors receive the treatment and support they need. The RANZCP welcomes the recommendations made by the Royal Commission in the *Redress and Civil Litigation Report* (2015) in this regards. In particular, recommendations nine and ten, that flexible, unlimited and appropriate counselling and psychological care should be made available to victims and survivors, facilitated by a public register. The RANZCP looks forward to continuing to work with the Royal Commission on developing this initiative.

We emphasise however that initiatives such as those led by the Royal Commission must be met with appropriate levels of public funding. If the service system capacity is not in place to meet demand, there is the risk that many opportunities for delivering essential supports to this vulnerable group will be missed. In the context of this issue, the RANZCP looks forward to contributing to and reviewing the details of the Commonwealth Government's response to the Australian Mental Health Commissions *Review of Mental Health Programmes and Services*, and its development of the *Fifth National Mental Health Plan*. In particular, the Government's commitment to implementing innovative funding models that will support consumers with severe and complex mental illness may have the potential to contribute to the capacity of the mental health system to provide adequate and holistic supports to survivors and victims of institutional child sexual abuse (Department of Health, 2015).

In terms of models for service delivery, this will vary depending on the needs of the victim or survivor, however in each case the clinician should be trained in delivering therapy using a range of modalities, matched to the needs of the individual and bearing in mind non-specific factors such as the therapeutic alliance between consumer and clinician which enables trust and open discussion. Secondary victims and survivors should also be assessed and indicated. Group therapy, including peer support groups, may be a useful component of the service. A range of individual therapies should be offered for as long as indicated.

Recommendations

- The RANZCP supports the Royal Commission's recommendations in the *Redress and Civil Litigation Report* for enabling access to appropriate, flexible and unlimited counselling and psychological, facilitated via a public register.
- Initiatives such as the public register must be matched with public services that are adequately funded to respond to what is likely to be an increase in referrals for victims and survivors with complex mental health issues.
- The RANZCP looks forward to contributing to, and reviewing in more detail, the Australian Government's proposals for the *Fifth National Mental Health Plan* with regards to how innovative funding models for consumers with severe and complex mental illness may have the capacity to enhance access to specialised public mental health services for victims and survivors of abuse.

3. **How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?**

Recommendations

- We suggest reference to the Network Child Abuse Prevention and Treatment Program, a collaborative project of the Open Society Institute, the Soros Foundations Network and the Children's Mental Health Alliance. We believe that aspects of this resource could be effectively adapted to the Australian context. Please refer to the list of references for more details (Lewis et al, 2004).

Topic E: Evidence and promising practices

1. **What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional child sexual abuse are**

emerging from practice-based evidence? Where are these available and who can access them?

Recommendations

- Individual trauma-focussed treatments, for example trauma-focussed CBT, have the best evidence. Please refer to question two below for references.

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

Recommendations

Please refer to the following resources, details in the reference list:

- Ehring et al, 2014:
  - Treatment of posttraumatic stress disorder (PTSD) is efficacious in survivors of child abuse.
  - Trauma-focused treatments show higher effect sizes than non-trauma-focused ones.
  - Individual treatments show higher effect sizes than pure group treatments.
  - More research is needed using rigorous methodology.
- Webb et al, 2014:
  - Trauma-informed CBT can be implemented effectively in community settings.
  - Treatment outcomes were similar to those reported in efficacy trials of trauma-informed CBT delivered in speciality clinic settings.
  - Improvements in PTSD symptoms and internalising and externalising problems were maintained up to one year after treatment began, although the changes in externalising symptoms were the least stable.
- Dorsey et al, 2014:
  - Findings suggested that young people who had experienced trauma, and their foster parents, who had received trauma-informed CBT plus evidence-based engagement strategies were more likely to be retained in treatment through four sessions and were less likely to drop out of treatment prematurely.
  - The engagement strategies did not appear to have an effect on the number of cancelled or no-show sessions or on treatment satisfaction.
  - Clinical outcomes did not differ by study condition, but exploratory analyses suggest that the young people had significant improvement with treatment.
  - Strategies that specifically target engagement may hold promise for increasing access to evidence-based treatments and for increasing likelihood of treatment completion.
- Bohus et al, 2013:
  - A modular treatment programme that combines principles of dialectical behaviour therapy and trauma-focused interventions (DBT-PTSD) was found to be efficacious in the treatment of childhood sexual abuse-related PTSD.
  - DBT-PTSD was efficacious even in the presence of severe co-occurring psychopathology such as borderline personality disorder.

- Mannarino et al, 2012:
    - In a study of children aged four to 11 years old who had experienced sexual abuse and who had been treated with trauma-focused CBT, findings suggested overall significant improvements across 14 outcome measures.
    - Higher levels of child internalising and depressive symptoms at pretreatment were predictive of the small minority of children who continued to meet full criteria for PTSD at the 12 month follow-up.

3. What other learning are emerging from practice-based evidence or from grey literature (i.e. published reports and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?

In an expert clinical survey organised by the International Society for Traumatic Stress Studies (ISTSS), a large group of experts recommended phase-based treatments for PTSD in cases of high symptom complexity, whereby a first non-trauma-focused phase (for example skills training) is followed by trauma-focused treatment (Cloitre et al, 2013). Examples of phase-based interventions that have been developed for the specific needs of childhood abuse survivors with PTSD are the Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure (STAIR/MPE) program (Cloitre et al, 2002) or DBT-PTSD (Bohus et al, 2013).

The World Health Organization (WHO) *Guidelines for Medico-Legal Care for Victims of Sexual Violence* shows that while the initial medical assessment of a child who has experienced sexual abuse may not reveal any immediate psychological problems, it is important that a further assessment be conducted to ensure that any issues that may arise are addressed and dealt with appropriately. Services should be provided in a coordinated fashion, and considered in conjunction with similar approaches by schools and other community groups. Thought must also be given to providing support and/or counselling to those caring for the child. This may be required even if the child itself if not assessed as needing therapy. The report goes on to make the following recommendations:

- Abuse-specific CBT is generally the most effective form of therapy for PTSD reactions.
- Group therapy for children is not necessarily more effective than individual therapy.
- Many victims and survivors of child sexual abuse may have comorbid conditions that require specific treatment.
- Younger children may not understand the implication of abuse and therefore may appear to be less distressed than older children.
- A believing and supportive mother or non-offending caretaker can be a strong determinant for a good prognosis (WHO, 2013).

Recommendations

- Consider the ISTSS's findings in support of a phase-based, or stepped, approach to treatment of survivors and victims of institutional child sexual abuse. Refer in particular to the STAIR/MPE program and DBT-PTSD.
- Refer to WHO's guidelines for a framework for supporting children who have experienced sexual abuse, in particular for the importance of monitoring or treating young children even when asymptomatic.

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