

## Issue paper 10.

### Advocacy and Support and Therapeutic Treatment Services.

*Submitted by Jo Walker, Resilience Matters.*

Underpinning any service for people impacted by Childhood sexual abuse, accepting people are often suffering from a trauma response is the "Three pillars model". This model, like the work of ASCA, emphasizes that for service to be affective for these clients it needs to focus on, safety, connection and managing emotional responses

Importance of **relational** services for the client group cannot be over emphasized. To recover, to live a life people need to not only talk (sometimes not talking at all) but to connect, connect with themselves, others and the community.

Healing Relationships need not always involve psychotherapy. Many people recover from trauma exposure ... processing and resolving their injuries in the context of family, friendships, and other relationships. (Briere & Scott, 2006)

For these clients building trust and maintaining safety is key - the best way to do this is via actual interactions and experiences with individuals and services.

Assisting survivors to move from chaos to stability is also important. Creating stability – in relationships, income, health care and accommodation cannot be over looked

We must remember that acknowledging a survivor as expert in own life and circumstances is key to effective service provision and support.

#### **Importance of Advocacy - neuroplasticity and capacity.**

For survivors of complex trauma (and by definition child sexual assault is complex trauma) effective advocacy is a must. Not as an optional add on or "opt in", but as a general right of all survivors. Opting out of advocacy should remain an option, but it is important that the baseline/starting point is established as everyone needs an advocate - some to a greater degree than others. Advocacy should be seen as a right and a feature of the wrap around service provided to survivors of Institutional Child Sexual Abuse.

Pitting survivors up against or in direct contact with the very institutions that hold responsibility for their abuse and lack of action/ in action/ lack of response creates a situation of re-traumatisation and impacts directly in a negative way upon survivors and their ability to function/cope or move on.

For example, asking a client to deal directly with Salvos for redress or accommodation etc. - or Drug & Alcohol treatment is neither appropriate nor therapeutically sound if recovery is truly sought to be the outcome.

Advocates are needed to address power imbalance between individuals and institutions. The institution will always represent abuse - no matter how recovery has been achieved for the individual.

\* Re traumatisation

## **Issues relating to fluidity of capacity**

Capacity in one area of functioning doesn't mean capacity will always consistently hold in all circumstances. A survivor may hold down a job and have a family however faced with possible direct contact or interaction with the institution or representatives of the institution in which they were abused may in fact impact upon that individuals "capacity"

We know many survivors when they feel overwhelmed revert to 'survival brain' - which can be disassociating or simply not able to retain information relayed to them.

Neuroplasticity and developments in the past decade have conclusively showed us that "survival brain" is not able to process information - the "executive functions" - higher levels of brain function when off line mean survivors when unable to access the functions of the pre frontal cortex and its effective operation.

If this is the case - where is the capacity to act - to make decisions in their own best interests if a survivor is functioning at this level - the fluidity of this state and unpredictability and ability of survivors to "survive" - to present as functioning and engaged when at their core they are not and in fact they can barely breath - means an advocate is a MUST

The question is does a survivor without prefrontal cortex operation really have capacity to make decisions - if yes then is it all decision or are some decisions more at risk or more impacted than others - e.g. can make a decision about what to eat or drink - but higher level more abstract decision making may be more at risk, more tentative more difficult ego, explaining to Centrelink why they are claiming DSP

Does a survivor who disassociates when having to think about their abuse/experiences - let alone have to deal with an institutional response - really possess legal capacity to engage in any redress process established and run by an institution or even a government established redress process - without an advocate.

Advocacy needs to remain a separate entity to legal representation. The role of an advocate in this forum needs to be clients focused/specific?. It is not something that needs to be tied to the legal profession. Advocacy is a necessity for a non-litigating approach. The role needs to rest with community based organisations and individuals who are able, such as support or social workers, who can not only advocate but also can offer ongoing case management as required.

Assuming the impacts of complex trauma on survivors does affect their ability to comprehend information, navigate any system and negotiate and advocate for themselves - then effective advocacy becomes pivotal / core to RC recommendations.

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

- Aging population of survivors – need to make sure service delivery in relevant institutions/services that provide assistance to older Australians are working within frame work of trauma informed practice, eg hospitals, nursing homes.
- Need for centralized service delivery for the client group via case management.
- Currently no case management has been funded via RC national counselling, glaring deficit in working with these clients. Currently case management is falling to ad hoc provision.
- Counselling is not enough – the impacts of trauma resonate, for many clients basic societal and relational interactions are clouded by lack of trust and lack of safety.
- Major government agencies also need to be working to assist these clients from a trauma informed perspective these include Centrelink, Police and Medicare. Staff need to be trained

to work with these clients in a respectful way, moving from what is wrong with you to what happened to you.

- Need to be seen – to no longer be invisible
- To be heard – to no longer be silenced
- To be validated in the relational engagement with professionals and services.
- Need for better assessment modalities.
- In meeting the needs of the particular client group need to also provide relevant and adequate training and support to works in the field to minimize impacts of the work, promotion of vicarious resilience (not vicarious trauma), post traumatic growth.
- Importance of community education about CSA, it's impacts and requirements for recovery. A way forward for individuals requires a societal response.
- This ties to issues relating to the need for societal education and discussion regarding gender and related issues.

### **Group work**

Therapeutic or psycho-social educational groups have an extremely important role in assisting in recovery for survivors. Providing a forum that is a safe medium to normalise and explore individual responses to abuse and trauma is key to building capacity and resilience for this client group.

Currently limited provision of groups is being undertaken for men, there needs to be more groups for men, not just in cities but particularly in regional and remote areas of Australia.

There also needs to be the same opportunities for group experiences for women, again not just in cities but across regional and remote areas of Australia.

The actual group process of forming, norming and storming provides a valuable modality to work with suffers of complex trauma. It allows individuals to develop connections with others, test boundaries in a safe and supported way.

### **Until now.....**

While survivors have been "invisible" in our community until the Royal Commission there is another group of people who also need both support and therapeutic treatment services. This is those people who have devoted their lives (often not intentionally) to survivors. Mothers, fathers, wives, husbands, brothers, sisters, children and partners of survivors have until now been even more invisible than the survivors themselves.

These people have daily stood beside survivors, companionship through ups and downs, highs and lows that non abused people, those not suffering from complex trauma, may feel overwhelmed by.

It is this group that would benefit from access to individual treatment services, but more importantly a closed psycho-social education group to assist them in understanding the presentation of their loved ones in the framework of Trauma informed modalities.

Such groups would provide opportunity for the informal supporters of survivors to share and learn from each other's experiences and to assist them in not feeling isolated.

## **Isolation and increasing informal non-therapeutic supports - - BEFRIENDING**

- many survivors struggle to maintain any positive relationships in their lives
- building trust/safety is key to assisting survivors heal.
- Scottish and English models for support services have effectively included a component of "Befriending".
- A therapeutic relationship is broadly an unconditional one - unlike friendships which do have conditions - Befriending allows survivors a sort of half way point to begin to learn to understand about relationships - development and maintenance - and to do so again is a safe supported way.

### **Topic B: Diverse victims and survivors**

- Victims are not of specific demographic, spread across the country, city and country, not of specific social or economic background nor of a specific cultural background.
- Aboriginal victims in particular face compounding layers of trauma that can't always be specified to a particular incident. Intergenerational cumulative effect of trauma in Aboriginal communities means services/ structures for this client group need to be broad to provide best assistance.
- There are barriers to accessing justice for Aboriginal client groups, tied to the poor experiences of "stolen generations", lack of long term funding creates a lack of stability and continuity for clients.
- Disabled clients – huge area. Could be offered support via NDIS
- Many clients present with various levels of disability
- Health issues for many clients are chronic.  
[http://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime](http://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime)

### **Topic C: Geographic considerations**

- As above, need to make use of developing technologies to best service this client group, particularly clients in rural and remote areas.
- Need for regional service delivery to consider "travel payment" as part of therapeutic engagement. Realistically the cost of fuel or transport can be prohibitive to those living on a fixed income, people have to currently choose whether to eat or whether to see a therapist.

### **Topic D: Service system issues.**

- Aim for non-competitive funding models
- Need for centralized co-ordination or service delivery.
- Overarching board/committee or panel comprised of senior representatives from various professions/bodies/disciplines that work with this client group or in this field.
- One stop shop model – co location of services – advocates, support and treatment services.
- Warm transfers – to minimize the need for survivors to have to "re-tell" their story.

- Information sharing key to effective service provision.
- Dual presentations: Trauma impacts often in conjunction with other issues such as Drug and Alcohol abuse – need to make service delivery seamless, again to minimize re traumatisation from having to “re-tell”.

**Topic E: Evidence and promising practices.**

- Body treatments – somatic
- Alternative therapies
- Peer learning
- Mentoring/advocacy/case management
- Apps – such as PTSD coach (USA DVA), smiling mind etc
- Online groups (such as those facilitated by 1in6)
- Skype
- Facetime
- Psycho-social education for survivors and supporters
- Mindfulness practices, particularly work of Jon Kabat Zinn – Mindfulness based stress reduction.
- Capacity and connection
- Vicarious resilience
- Trauma Symptom inventory – John Briere
- Babette Rothschild
- Judith Herman
- Integrated substance abuse and trauma treatment programs such as TRIAD (developed and used in US)

**References.**

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Treating adult survivors of severe childhood abuse and neglect:

Further development of an integrative model

John Briere, Ph.D.

Department of Psychiatry and the Behavioral Sciences

Keck School of Medicine

University of Southern California

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