Adult Survivor Pilot Action Research Project: Final Report

August 2022

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Statement of Acknowledgement and commitment to Aboriginal people, families and communities

The research team and participants in this research project recognise Aboriginal and Torres Strait Islander peoples as the First Nations' People of Australia. We would like to express our gratitude to the traditional custodians of the lands on which we undertook the Adult Survivor Pilot Research Project. We are grateful to have worked on the Gumbaynggirr, Dunghutti, Birpai, and Nganyaywana nations on the Mid North Coast and on the lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples at South East Sydney.

The research team acknowledge and are incredibly saddened by the impacts of historical policies and actions that have been, and continue to be, harmful for Aboriginal people. We understand that current systems continue to perpetuate violence and abuse, leading to social and economic oppression for Aboriginal people, families and communities. For Aboriginal people who have been subjected to childhood sexual abuse, particularly in the context of institutions, we send our heartfelt apologies. We understand that your experience of trauma as a result of childhood sexual abuse must be understood in the broader context of colonisation, racism, genocide, multiple bereavements and other losses, and the forced removal of children from their families, communities and culture. We understand the ongoing impacts are profound with loss, grief, and disconnection.

We acknowledge and thank your leaders, past, present and emerging for their tireless and continuous work to right the past wrongs. For their acts of resistance and continuing to fight against oppression and ongoing impacts of racism and colonisation on a daily basis, whilst holding an energy and commitment to keeping families and communities safe whilst addressing the ongoing impacts of intergenerational trauma. We value guidance on ways of healing that can be mediated by Aboriginal-led models and culturally appropriate services that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. We have been privileged and honoured to be able to work in this space with Aboriginal colleagues and build collaborative learning from their extensive wisdom and expertise.

Glossary of Terms and Acronyms

Term/Acronym	Description
ACCHO	Aboriginal Community Controlled Health Organisation
Adult Survivor of Childhood Sexual Abuse	A person who has experienced childhood sexual abuse is referred to as an adult survivor in this report.
ASAG	Aboriginal Specialist Advisory Group
AH&MRC	Aboriginal Health and Medical Research Council
AOD	Alcohol and other Drugs
ASP	Adult Survivor Pilot
Adult Survivor Pilot Project	The overarching Adult Survivor Pilot Project includes: set up and establishment phase of the pilot, Expression of Interest process and selection of the pilot sites, the ASP Research Project and statewide implementation.
Adult Survivor Pilot Research Project	The Adult Survivor Pilot Research Project includes the four research stages as outlined in this report that aimed to simultaneously develop and evaluate a new service for adult survivors through action research.
Adult Survivor Pilot Local Project Team	The Local Project Team that implemented the project at each site for the Adult Survivor Pilot Project and Research Project. In SESLHD this included a project lead, a clinical lead and trauma clinicians. In the MNCLHD this changed throughout the Research Project but in the action research stage included a project lead, an Aboriginal project lead and clinician.
Childhood Sexual Abuse (CSA)	Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child. We considered the production, consumption, dissemination and exchange of child sexual exploitation material to be child sexual abuse.
Complex trauma	It is a particular type of victimisation that gives rise to complex trauma, usually prolonged or multiple types of interpersonal abuse. It often commences at an early age, thereby affecting emotional development and often the perpetrator is an authoritative figure in the victim's life. The variety of impacts arising from sustained or chronic trauma has resulted in the development of the concept of complex trauma to reflect the varying symptomatology, co-occurring disorders and multiple adverse experiences that combine to impact on victim/survivors of multiple or ongoing and interpersonal traumas such as childhood sexual abuse[1].

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[1] Wall & Quadara (2014).

Cultural safety	Cultural safety is a concept that aims to recognise, respect and nurture the unique cultural identity of a person in order to create safety for them and meet their needs, expectations and rights. This is critical both within and outside the workplace. It is based on a reciprocal relationship which involves balancing the giving and receiving of trust, transparency, connectedness, sharing, equality, safety and shared responsibility.
HREC	Human Research Ethics Committee
LHD	Local Health District
Intersectionality	Intersectionality refers in this report to people's differential experiences of violence and abuse and how they are influenced by different forms of oppression including sexism, racism, ableism, homophobia, and other aspects of identity. Taking an intersectional approach means recognising that the barriers to seeking support, and the particular forms of violence that survivors from some groups experience, are not only driven by sexism and gender inequality, but also by other forms of discrimination.
MH	Mental Health
MNCLHD	Mid North Coast Local Health District
NGO	Non-government Organisation
NH&MRC	National Health and Medical Research Council
PARVAN	Prevention and Response to Violence Abuse and Neglect
Participant	Refers to a person who participated in the Adult Survivor Pilot Research Project.
Priority Populations	The term 'priority populations' refers to diverse groups for whom there is significant evidence of heightened vulnerability to violence and abuse, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors, and experiences of discrimination.
SAS	Sexual Assault Service
SASAAP	Sexual Assault Services Aboriginal Action Plan
SESLHD	South Eastern Sydney Local Health District
SHN	Specialty Health Network
Trauma-informed Approaches	The Royal Commission describe trauma-informed approaches as 'frameworks and strategies to ensure that the practices, policies and culture of an organisation, and its staff, understand, recognise and respond to the effects of trauma on client wellbeing and behaviour' (Vol 9. page 33).
VAN	Violence Abuse and Neglect
Violence-informed approach	Violence informed approaches expand on the concept of a trauma-informed approach. It takes into account the intersecting impacts of systemic and interpersonal violence and structural inequities of a persons' life.

Executive Summary

The findings of the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) highlighted significant gaps and failings in service provision for adult survivors of child sexual abuse. One of the key recommendations of the Royal Commission was that governments address existing sexual assault service gaps to provide advocacy and support and specialist therapeutic treatment for victims and survivors (Recommendation 9.6). In response, NSW Health committed to enhancing the capacity of its Sexual Assault Services through piloting an integrated service delivery approach for adult survivors of child sexual abuse, with local Mental Health Services, Alcohol and other Drug Services, and relevant community organisations. The *Adult Survivor Pilot Project: Specialist, integrated service for adult survivors of child sexual abuse with complex needs*, was undertaken for three years from 2019 to 2022.

The Adult Survivor Pilot (ASP) Project was innovative in its approach in that it used action research to simultaneously develop *and* evaluate a new service response for adult survivors in two Local Health Districts (LHDs) in NSW. This was in direct contrast to other evaluative approaches that generally examine the effectiveness of services after they have been set up and operating for a period of time. CLT Byron Consulting was commissioned to undertake the service development and evaluation of the pilot sites using action research (the ASP Research Project). The aims of the research were: 1) to use an action research approach to develop locally driven, ground-up service models responding to local and contextual needs, and 2) collect evaluative data exploring effective service responses for adult survivors which would be used to inform a state-wide roll out strategy and implementation of appropriate services for adult survivors in NSW Health.

The ASP Research Project was conducted at two sites, the South Eastern Sydney Local Health District (SESLHD) and the Mid North Coast Local Health District (MNCLHD), the successful applicants of an Expression of Interest process led by the Ministry of Health in 2019. The two sites were contextually different with varying demographics, sector capacity, geography, local community need, and local infrastructure and resources. Both aimed to develop new service responses for adult survivors of child sexual abuse in their local areas drawing on local practice expertise.

The research team worked alongside the two sites embedding the action research. The project aimed to explore:

- How do workers across the Health system conceptualise and respond to adult survivors of childhood sexual assault when they are faced with co-occurring issues?
- How do workers, as part of case management, community development and broader capacity building initiatives assess and manage the complexity of the intersections of Sexual Assault, Mental Health, and Alcohol and Other Drug use with adult survivors of childhood sexual assault?
- What formal collaborative arrangements are required for workers and their organisations to work with adult survivors?
- How does the survivor's voice influence the responsive work?
- Which staff are able to provide a specialist response and what are their training and capacity needs? What are the training and capacity building needs for the broader Health sector to best respond to adult survivors?

- How are priority populations thought about in service provision? How is the service model being developed for these cohorts?
- What are the issues for Aboriginal people, families, and communities? How do we assess what a culturally safe and responsive service may look like physically and from a practice lens?
- How can a trauma-informed approach build common understandings and integrated responses to adult survivors, regardless of their point of presentation?

This report provides the detail of the Adult Survivor Pilot service development through action research and a description of the research findings to support the state-wide implementation work. The report is divided into seven sections.

Section One provides background to the ASP Research Project and includes the rationale for undertaking the project and the connection to the Royal Commission's recommendations, why the intersecting issues of Alcohol and other Drug, Mental Health, and Sexual Assault are important considerations, and how the three distinct service sectors currently respond to adult survivors within the broader Health context. This section also provides detail on how the two pilot research sites – the Mid North Coast Local Health District (MNCLHD) and the South Eastern Sydney Local Health District (SESLHD) were chosen to participate.

Section Two describes the approach to the research, including the principles underpinning participatory action research, and details the four stages of the ASP Research Project: (i) consultation, scoping and initial engagement with the research sites; (ii) developing a Community of Practice as a site of partnership development and data collection, (iii) development of new service responses through action research; and (iv) consolidation of the key findings and learnings.

Section Three: outlines the research methodology, including research questions, ethics approval processes, data collection and data analysis. It describes how the data collected was used iteratively throughout the life of the project to inform each developmental stage.

Sections Four and Five: provide a description of the service development and action research processes at each site. The local and specific needs and context of the geographical areas are described and a clear picture of how the service response for adult survivors was developed using practitioner-led, ground-up approaches and expertise is provided. The work of the Community of Practice at each site is described as the source of new knowledge production and as an effective way to share expertise, acquire skills, and develop collaborative ways of working.

Section Six: highlights the ASP Research Project's key findings. These findings include: the contribution of an action research project to developing locally-led and contextually appropriate service responses; core practice principles that are essential to underpin responses to adult survivors of child sexual abuse; appropriate and effective services responses for adult survivors and what these look like; learnings for developing a safe service for Aboriginal people, families, communities and staff; elements that drive collaborative work at the intersections (re-defining integration); the importance of capacity building and training for the broader Health system; workforce essentials; and sustaining system-wide change.

Section Seven: provides recommendations for state-wide implementation of service responses for adult survivors of child sexual assault.

Key findings

The findings from this research were consistent with those of the Royal Commission, that is, the importance of: a flexible approach, collaborative practices, developing culturally safe services for First Nations people, families and communities, and responses embedded with a trauma-informed approach. However, the unique aspect of this project was eliciting data that explored developing these responses in a Health setting. The following learnings can be used to support broader state-wide implementation.

1. Moving from a ‘service centred’ to ‘client-centred’ approach.

A new service for adult survivors requires a transformational shift from an emphasis on diagnosis and the expertise of the practitioner, to survivor-centred practices. This is consistent with the move towards trauma-informed care in NSW Health, where considerations of power and commitment to rectifying unequal power imbalances in the service/client relationship are key. Slow and considered engagement, coupled with a focus on developing a partnership with the client, should be the priority.

2. A move from ‘business as usual’: flexible and responsive approaches.

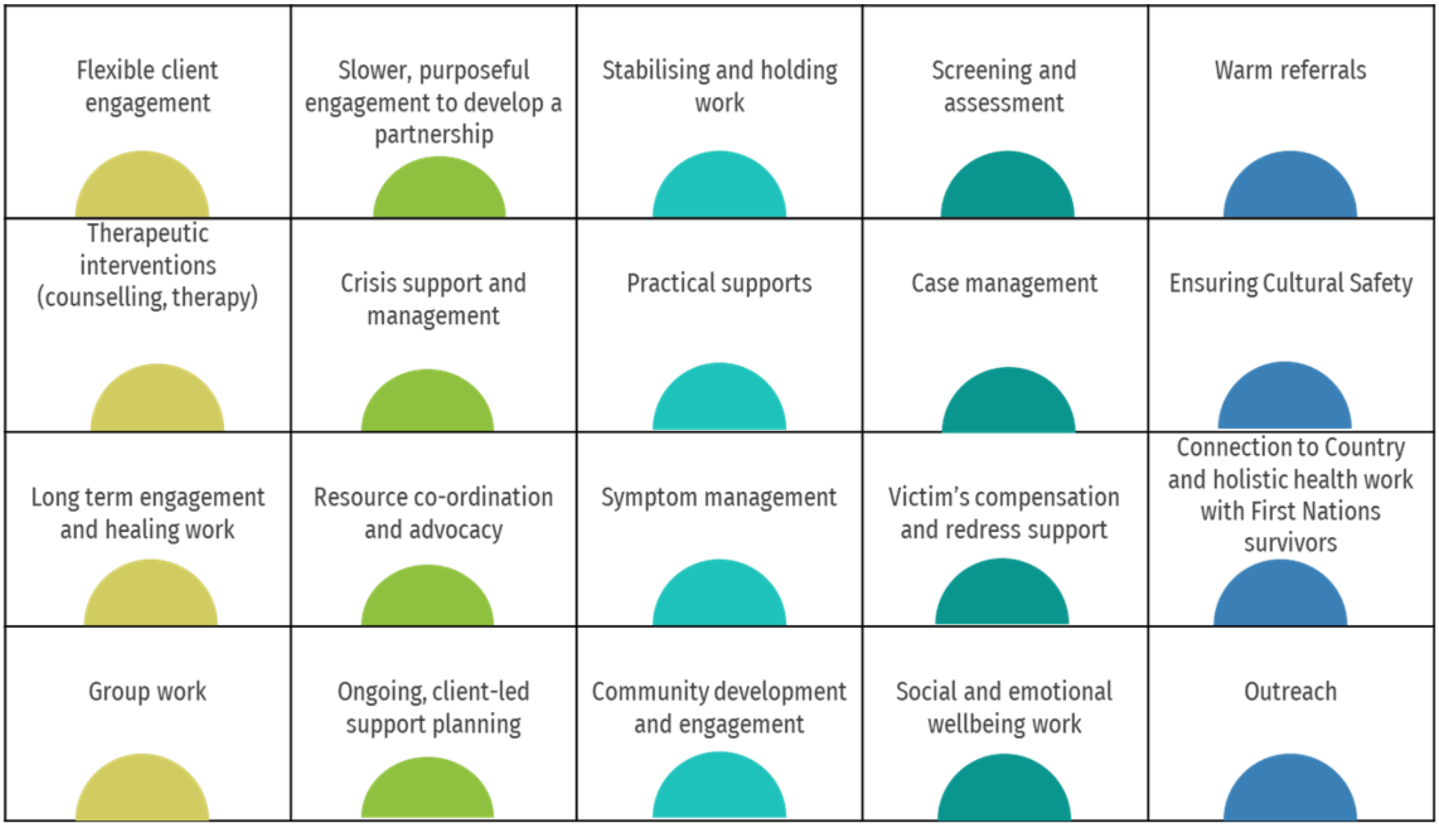
The findings highlight a move from traditional Health responses of diagnosing, treating, and referring, to developing practices that are flexible and responsive, focusing on proximate changes for the client that add up to longer-term changes in their life are effective. Re-defining ‘client readiness’, moving beyond treating only the symptoms of abuse, pro-active engagement and non-punitive approaches are key. Considerations of time and space are important in the practice response and should reflect the needs of the client.

3. A framework to underpin practice: drawing on foundational understandings.

Using a trauma-informed and violence-informed approach that draws on an understanding of intersectionality is critical to underpin all practice responses for adult survivors of child sexual abuse. Developing a service that is culturally safe and responsive, through embedding practices that are safe and appropriate for Aboriginal people, families and communities must underpin all responses.

4. Direct client work: key areas of practice.

A range of practice responses were trialed through the action research. The following table highlights the breadth of direct client work that supported adult survivors on their journey. These should be core to any specialist service for adult survivors.



Flexible client engagement	Slower, purposeful engagement to develop a partnership	Stabilising and holding work	Screening and assessment	Warm referrals
Therapeutic interventions (counselling, therapy)	Crisis support and management	Practical supports	Case management	Ensuring Cultural Safety
Long term engagement and healing work	Resource co-ordination and advocacy	Symptom management	Victim's compensation and redress support	Connection to Country and holistic health work with First Nations survivors
Group work	Ongoing, client-led support planning	Community development and engagement	Social and emotional wellbeing work	Outreach

Figure 1: Direct client work: key areas of practice

5. Capacity building and training to support the service system.

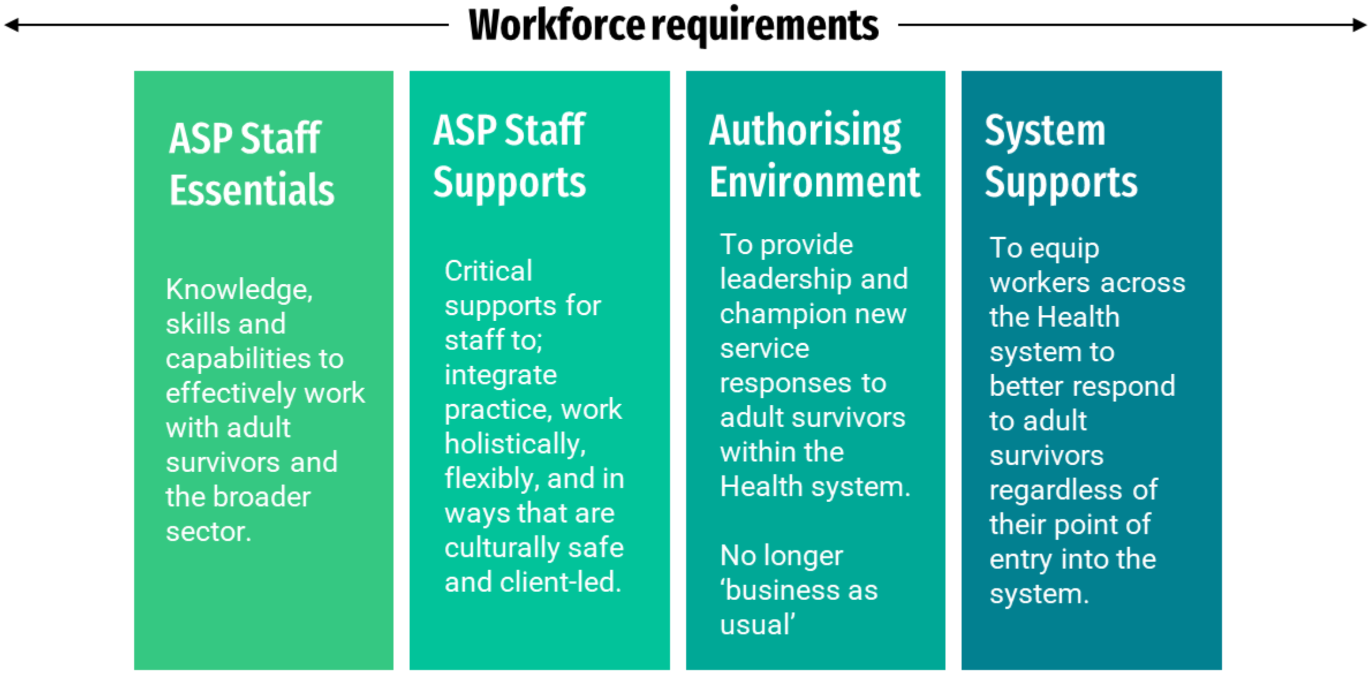
A single service in each Local Health District cannot provide service to the overwhelming number of adult survivors of sexual abuse requiring support, many of whom are already clients of Health services. The data identified that if workers across the system are skilled up in seeing and understanding the impacts of childhood sexual abuse and how these impacts present in a range of health settings, more adult survivors will receive an appropriate and holistic response. Any specialist adult survivor service has a vital role to play in mobilising broader Health Services and building their capacity to respond to all adult survivors no matter their point of presentation in the Health system.

6. Re-defining integration: a move to collaboration.

The Alcohol and other Drug, Mental Health, and Violence, Abuse and Neglect sectors are entrenched in their own work cultures. Work to 'integrate' these 'silos' requires time, an authorising environment that strongly supports strategic level partnerships, a broader distribution of power, and a shift from the embedded culture of medical model approaches. Re-framing the service 'integration' across these sectors as 'collaboration' opens the space for services to retain their own expertise and approaches, whilst at the same time working on the shared issue and understanding of that issue. The new Adult Survivor Service should champion collaborative working approaches, starting with effective partnerships.

7. The importance of a skilled and trained workforce.

When developing service responses for adult survivors, it is important to think of both staff of the new specialist adult survivor service, as well as the broader workforce within the Health system who regularly have contact with adult survivors. Staff working in a new adult survivor service team require targeted skills, capabilities and knowledge to effectively respond. To scaffold the work of those practitioners, critical supports that allow staff to work flexibly, holistically and in ways that are culturally safe and responsive, and client led are key. The diagram below highlights both the essential skills required of staff as well as the necessary structural and system supports.



Workforce requirements

ASP Staff Essentials

Knowledge, skills and capabilities to effectively work with adult survivors and the broader sector.

ASP Staff Supports

Critical supports for staff to; integrate practice, work holistically, flexibly, and in ways that are culturally safe and client-led.

Authorising Environment

To provide leadership and champion new service responses to adult survivors within the Health system.

No longer 'business as usual'

System Supports

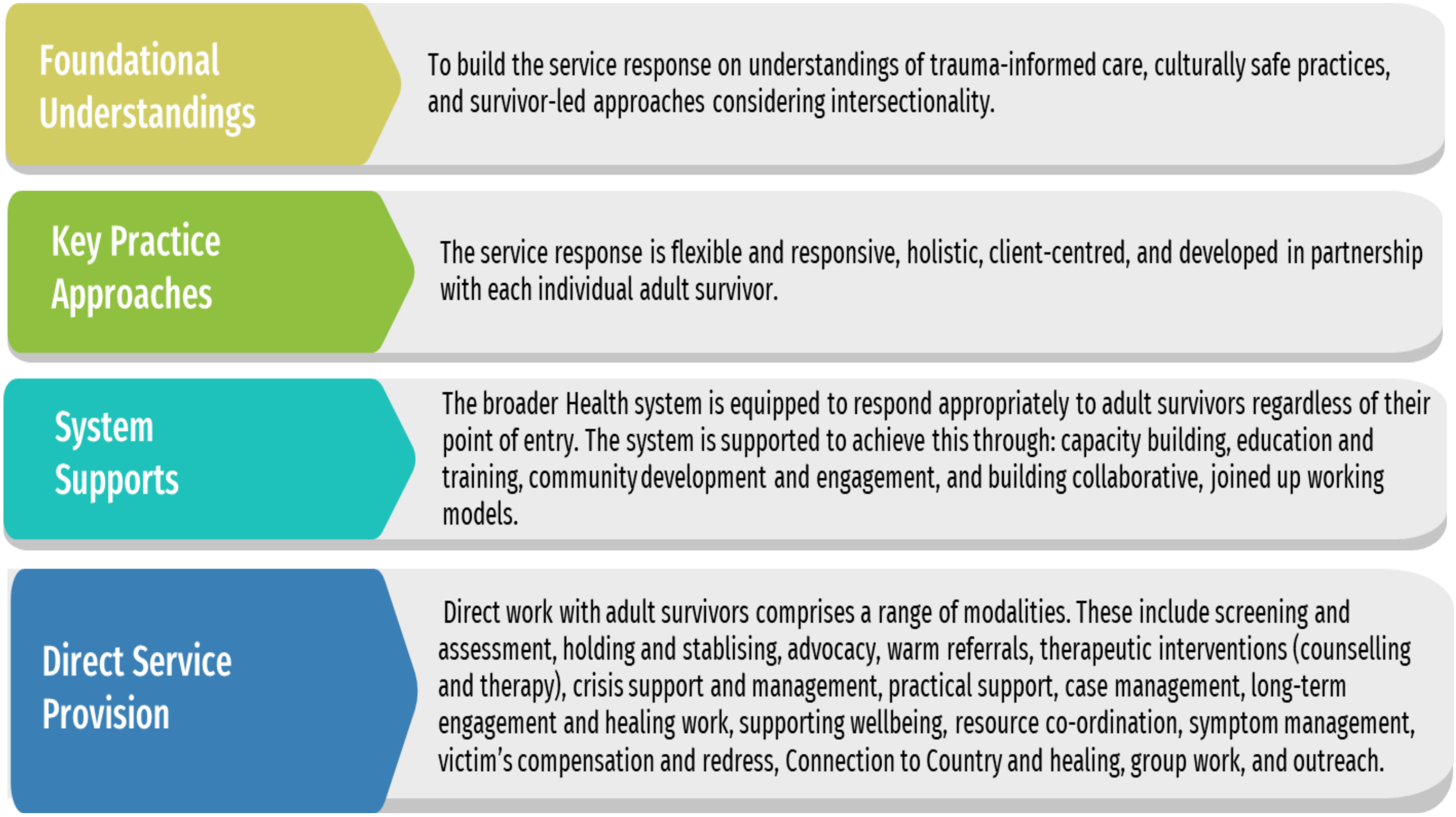
To equip workers across the Health system to better respond to adult survivors regardless of their point of entry into the system.

Figure 2: Workforce and system essentials

8. A practice response framework

The following diagram outlines the minimum components required for an effective service response across NSW Health for adult survivors. The components include:

- Essential foundational understandings and theoretical underpinnings,
- key practice approaches,
- supports for the broader Health system, and
- direct service provision modalities.



Foundational Understandings

To build the service response on understandings of trauma-informed care, culturally safe practices, and survivor-led approaches considering intersectionality.

Key Practice Approaches

The service response is flexible and responsive, holistic, client-centred, and developed in partnership with each individual adult survivor.

System Supports

The broader Health system is equipped to respond appropriately to adult survivors regardless of their point of entry. The system is supported to achieve this through: capacity building, education and training, community development and engagement, and building collaborative, joined up working models.

Direct Service Provision

Direct work with adult survivors comprises a range of modalities. These include screening and assessment, holding and stablising, advocacy, warm referrals, therapeutic interventions (counselling and therapy), crisis support and management, practical support, case management, long-term engagement and healing work, supporting wellbeing, resource co-ordination, symptom management, victim's compensation and redress, Connection to Country and healing, group work, and outreach.

Figure 3: A practice response framework

9. Acknowledging the opportunities and barriers in each specific geographic context

A new service must be responsive to its own service environment. It is critical that unique iterations of the new service will reflect the demographics, contextual factors and needs of the local area. Key considerations about staffing, sector capacity, geography, client demographics, local community needs, local infrastructure and resources must be acknowledged and built into any new service model. This report recommends the critical components of a survivor service, but the ways in which these components are developed will be shaped by the unique service context in each Local Health District

Section One: Background and context

1. The Royal Commission into Institutional Responses to Child Sexual Abuse recommendations

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) was established to inquire into and report upon responses by institutions to instances and allegations of child sexual abuse in Australia. The findings highlighted significant gaps and failings in service provision for adult survivors of child sexual abuse. One of the key recommendations of the Royal Commission was that governments address gaps existing in service responses to victims of childhood sexual abuse. The Royal Commission recommended that governments should enhance sexual assault services by providing specialist therapeutic treatment for victims and survivors of child sexual abuse (Rec 9.6). The Royal Commission recommended that these specialist services:

- be trauma-informed and have an understanding of institutional child sexual abuse,
- be collaborative, available, accessible, acceptable and high quality,
- use collaborative community development approaches,
- provide staff with supervision and professional development, and
- be subjected to rigorous evaluation processes.[2]

2. NSW Health's commitments to respond to adult survivors' needs

In response to the Royal Commission recommendations, NSW Health committed to enhancing the capacity of its Sexual Assault Services through piloting an integrated or coordinated case management service model for adult survivors of child sexual abuse, with local Mental Health Services, Alcohol and other Drug Services, and relevant community organisations.

The Pilot Project: *specialist, integrated service for adult survivors of child sexual abuse with complex needs*, was undertaken for three years from 2019 to 2022. It was anticipated following the Pilot Project, that a new specialist service model for adult survivors of child sexual abuse would be implemented state-wide, from 2022-2023. Two pilot sites (Local Health Districts) were selected by the Ministry of Health to develop a locally led, ground up, contextually responsive service for their area. The pilots were evaluated through an action research process to develop learnings for state-wide implementation.

Through the NSW Government response to the Royal Commission, NSW Health committed approximately $1 million per local health district, per annum, for three years to June 2022, for each of the two successful sites to pilot the new service and participate in activities required to support state-wide implementation. Following the pilot period, approximately $6.4 million in total ongoing funding will be allocated through the NSW Health Royal Commission funding package across all districts to support state-wide coverage of the service.

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[2] Royal Commission into Institutional Response to Child Sexual Abuse (2017).

3. Childhood sexual abuse and adult survivors: what the literature tells us about service responses

Through the establishment phase of the Adult Survivors Pilot Project, CLT Byron Consulting was commissioned by the Ministry of Health to undertake a systematic literature review. The review provides a synthesis of the current literature exploring qualitative and quantitative evidence of responses to working with adult survivors of childhood sexual abuse, with a particular focus on mental health and alcohol and other drug use, as well as effective collaborative and integrated responses to adult survivors and those who have experienced violence. Responses for Aboriginal people, families and communities and the impact of intergenerational trauma were also explored.

Mental health, drug and alcohol use and childhood sexual abuse: a complex connection

A number of studies describe the intersections between childhood sexual abuse, mental health issues, and alcohol and other drug use, as strong but 'complex'.[3] These intersections and subsequent ways in which survivors present to health services create a complicated 'clinical picture'.[4] Those with histories of childhood sexual abuse are more likely to report problems associated with drug and alcohol use and misuse than those without histories of child abuse and ongoing mental health issues can often be exacerbated by drug and alcohol abuse. Alongside this, studies have found that experiences of abuse are often associated with the development of a range of mental health issues including anxiety disorders, depression, complex trauma impacts, self-harm, eating disorders, suicidality, and psychotic and dissociative disorders including borderline personality disorders. Experiencing mental illness often coincides with other complex issues. This may be in part because trauma resulting from child sexual abuse is not associated with a unique set of symptoms and often occurs in the context of other types of abuse. The effects or 'symptoms' of abuse most often become the presenting problem for treatment or intervention rather than the childhood abuse itself.[5]

How do the three service sectors (Mental Health, Alcohol and other Drug, and Sexual Assault) work together?

The literature review also found that whilst the connection between sexual assault, mental health, and alcohol and other drug use is clear (and there is a range of literature aiming to understand these connections), there is limited evidence that highlights collaborative, integrated practice and approaches that aim to support adult survivors across these three distinct service sectors. The literature also highlighted that despite the recognition of the importance of integrated Mental Health, Alcohol and other Drug, and Sexual Assault Services to respond appropriately to adult survivors,[6] service provision still remains siloed and at times disjointed with little or no integrated responses. Broadly, services have been operating separately with differing entry and referral criteria for clients as well as assessment processes. Limited resourcing often restricted the ability of services to provide wrap around and continued care to treat and address underlying trauma whilst maintaining safety and stability at crisis presentations. A devastating outcome of siloed working leaves survivors often falling through the gaps of service provision.

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[3] Breckenridge, Salter & Shaw (2010).

[4] Ibid Page 17.

[5] Toivonen (2019 Forthcoming).

[6] Breckenridge, Salter & Shaw (2012).

4. Aims of the Adult Survivor Pilot Research Project

The action research, service development and evaluation stream of the Adult Survivor Pilot (ASP) Project (the Research Project) sat within the broader Adult Survivor Pilot Project. The aims of the Adult Survivor Pilot Research Project were:

> 1) to use an action research approach to develop locally driven, ground-up service models in two pilot sites in NSW responding to local and contextual needs, and
>
> 2) through the action research process, simultaneously collect evaluative data exploring effective service responses for adult survivors which would be used to inform a state-wide roll out strategy and implementation of appropriate services for adult survivors.

5. Selection of the pilot sites

Responding to an Expression of Interest

In 2019, NSW Health Sexual Assault Services were invited by the Ministry of Health to respond to an Expression of Interest (EOI) to receive funding to run the ASP in their Local Health District (LHD) or Specialty Health Network (SHN). Successful LHD/SHNs would obtain funding to support the development and delivery of integrated, person-centred care to improve health and wellbeing outcomes for adult survivors of childhood sexual abuse, whilst simultaneously being participants in an action research study.

The EOI selection criteria and overarching approach was underpinned by six key concepts which were developed from the literature exploring collaborative approaches to working across service sectors in the prevention and response of violence, abuse and neglect space. These included:

- A commitment to the action research process ensuring reflective and critical approaches to service development.
- Establishment of an authorising environment for the evaluation of the pilot.
- A commitment to collaborative and integrated practice.
- A commitment to training and ongoing professional development.
- Alignment with current NSW Health frameworks and policy.
- A commitment to working alongside and being guided by Aboriginal people and communities.

Survivor-led site selection

Guidance from adult survivors was critical to the site selection process. To ensure this, *The Consumer Participation and Co-design Capacity Building* project was developed as part of the broader ASP Project. This establishment project undertaken by CLT Byron Consulting, was based on developing a best practice approach to consumer or survivor-led participation in the sector which moved beyond tokenistic engagement processes and was based on a commitment to working in partnership at a peer level with adult survivors. The project aimed to shift taken-for-granted, ‘professional’ understandings of service development and delivery and move towards a service user-led approach. This project aimed to also build capacity within the Ministry of Health, working alongside the Program Delivery Office (PDO) staff in the Government Relations Branch, to ensure that processes around the adult-survivor pilot project were consumer-led and involved the survivors in a meaningful, safe and trauma-informed way.

CLT Byron Consulting worked closely with two Survivor Advocates across the application and selection process, embedding their expertise in the selection of the pilot sites. A selection panel which was chaired by the Ministry of Health and was made up of representatives from PARVAN, Centre for Aboriginal Health, Centre for Alcohol and Other Drugs, Mental Health Branch, an Independent Researcher and two survivor advocates was established. Both Ministry staff and survivor advocates assessed applications against the selection criteria and provided advice on ranking and selection of the pilot sites. The two successful pilot sites were: South Eastern Sydney Local Health District (SESLHD) (Site 1) and the Mid North Coast Local Health District (MNCLHD) (Site 2).

Section Two: The research approach

1. A participatory approach to research and evaluation design

There are a number of approaches to iterative research and evaluation processes, whether they are conceptualised as practice-led research, action research, participatory action research, or co-design. The key element in any of these approaches is that knowledge is developed and captured through action, reflection, and practice. A participatory approach to service development and evaluation involves researchers, practitioners, policy makers and service users collaborating through all stages of the process, from the initial setting up of the research methodology through to dissemination of findings.

A co-design approach embraces the expertise of key stakeholders who are invited into the problem definition and development of solutions rather than traditional public policy development processes guided by key ‘experts’ using a top-down approach. The key features of co-design that align with the ASP Research Project included valuing innovative and alternative approaches, and cooperative and collaborative design. The engagement of practitioners, policy makers and survivors as active members of the process was critical.

2. Using an action research approach for the development and evaluation of the pilot site service responses

The systematic literature review (referred to in 1.1 of this report) highlighted that at the time of writing, there were no peer reviewed or rigorously evaluated service models designed to support adult survivors of childhood sexual assault that encompassed a collaborative or integrated service response from three distinct sectors: Sexual Assault, Mental Health, and Alcohol and other Drugs. Further scoping of health service responses showed that there were no identified collaborative approaches or service responses for adult survivors of child sexual abuse already in place in the selected LHDs that could be built upon and readily evaluated using a more traditional service evaluation approach.

In response, the Ministry of Health decided on an action research approach as the most appropriate way of developing and evaluating a new integrated model for the two pilot sites. This approach was preferable for the ASP project as:

- It would best respond to the complexity of the experiences of adult survivors of childhood sexual abuse and the range of services they engage with.
- Action research is commonly used to develop and evaluate current practice and policy in violence, abuse, and neglect services and to develop and evaluate current practice and policy.
- Experimental and quasi-experimental research designs are uncommon in research and evaluation that examines service responses to violence abuse and neglect, due to the difficulties in isolating and studying the impact of single interventions in real world contexts. Experimental research is designed to compare two equivalent groups to establish whether an intervention makes a difference. To establish equivalence between the compared groups, random allocation to either the control or experimental

condition is used. Because this type of design usually means that the control group does not receive an intervention, it is rarely appropriate for use with victims of violence abuse and neglect, particularly when they are in a situation of crisis and have experienced significant trauma.

In its essence, action research seeks to simultaneously produce knowledge and to implement change through continuous cyclical processes of planning, acting, systematic observation, and reflection.[7] As action research is not a methodology but rather an approach to producing evidence that explicitly encourages action and change throughout the process (rather than the more typical approach of waiting to find out the results of an evaluation), it allowed the researchers to draw on a range methodological approaches and data collection methods which were co-designed with key stakeholders at the pilot sites, responding to local need and capacity.

It was anticipated through the action research project, practitioners working in Sexual Assault, Mental Health, and Alcohol and other Drug services, Aboriginal Community Controlled Health Organisations, and NGOs would engage in iterative work that would a) develop and improve collaborative practice, and b) develop a co-designed integrated service model. The strength of using an action research process here, lay in its focus on generating local solutions to practical problems and its ability to empower practitioners, by allowing them to engage with and be active participants in both the research and the subsequent development of new practice. In the ASP Research Project, it involved local practitioners conducting systematic enquiries in order to help them improve their own practices, services, and broader systems.

The research methodology was informed by three foundational pieces of work that CLT Byron Consulting was commissioned by the Ministry of Health to develop through the establishment phase of the Pilot Project (July-Dec 2019), which are:

1. *The Adult Survivor Pilot: Pilot Site Selection Methodology Paper*
2. *The Adult Survivor Pilot: Consumer Participation and Co-design Capacity Building Report*
3. A literature review - *Responding to Adult Survivors of Child Sexual Abuse Across Three Distinct Service Sectors: A review of the current literature.*

3. Key principles underpinning the action research and service development

The following principles were developed for the ASP Research Project and were key considerations as priorities for the design of the methodology.

- The clear identification of a problem characterises the starting point for most iterative research processes whether they are conceptualised as practice-led research, action research, or co-design.
- Feminist research principles should inform the research design, aiming to ensure that strategies are developed to address power differentials between researchers, practitioners, and other participants, including adult survivors and clients.
- Evaluation and research of public health programs and initiatives are built on strong collaboration between researchers, practitioners and policy makers, and should include the voices of those most affected by policies and services – the adult survivors.

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[7] Alston & Bowles (2003); Craig (2009).

- The need to balance making survivors' voices central to the research with the ethical requirement to their safety and well-being. The key conceptual underpinnings of the *Consumer Participation and Co-design Capacity Building Report* were core to the methodology for the ASP.
- Understanding of the dynamics of violence, abuse and neglect which shape sexual assault service delivery, research, and evaluation should underpin the research design.
- Taking into account experiences of diverse cohorts is key. This includes Aboriginal and Torres Strait Islander people; people who are culturally and linguistically diverse, including migrants and refugees; people with a disability; lesbian, gay, bisexual, transgender, queer and intersex (LGBTI) people; people experiencing mental illness; people who have been incarcerated; older and younger women; and women in pregnancy and early motherhood.
- The design should be consistent with the methodologies used in Australian evaluations of responses to childhood survivors of sexual abuse, and those who have experienced violence, abuse and neglect.
- All interventions and system developments should be evaluated against the core principles of good practice with adult survivors of child sexual abuse identified in the Australian and international literature.
- The evaluation component of the methodology should be responsive to local need.

4. A staged and developmental approach

Overview

The ASP local service model development and evaluation through action research was conducted through a series of interconnected stages. An initial stage (Stage One) used scoping and consulting approaches with the two sites to develop an understanding of: resources, staff capacity, current service provision, inter-agency partnerships, internal health services' relationships, and aimed to support the set-up of structures that would support the development of a new service model. Stage Two focused on developing Communities of Practice and further embedding the advisory and governance structures in each site. Stage Three focused on the development of a service model through an action research process. The final stage (Stage Four) saw consolidation of key learnings from previous stages to inform an implementation strategy for state-wide roll out of a new service and program model in NSW Health from 2022-2023.

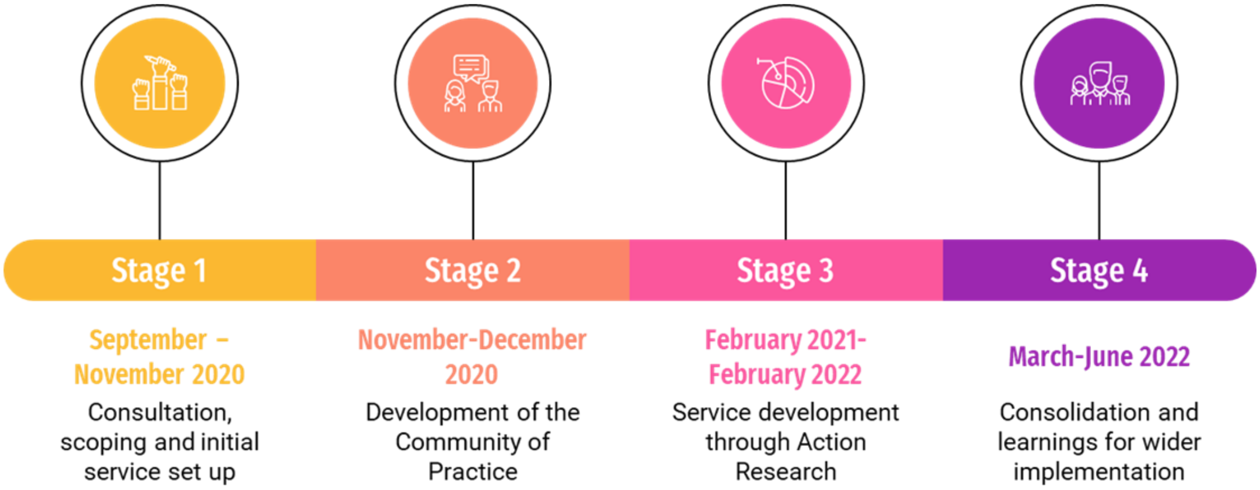

Figure 4: The four research stages

Stage One: Consultation, scoping, and initial service set-up

Stage One involved developing an understanding of local context in each research site. This stage drew from the model developed by Graham and colleagues,[8] which clearly articulates the processes of knowledge creation and the inquiry process combined with the iterative processes associated with adapting and monitoring the initiative in the local context. Key stakeholders were identified in each site, developed through local knowledge in a co-design process with the researchers. Representation was sought from the following services from both the NGO and NSW Health sectors: Sexual Assault Services, Mental Health Services, Drug and Alcohol Services, Aboriginal Community Controlled Health Organisations, specific adult survivor services or groups, individual trauma-informed counsellors, and adult survivors. Representatives from priority populations were approached to participate through consultation with community representatives. Interviews, meetings and consultation sessions were held to establish the 'starting point' at each site.

Stage Two: Development of Communities of Practice (CoP)

Stage Two drew on the information obtained during Stage One to assist in the generation of models of co-ordinated responses from Sexual Assault, Mental Health and Drug and Alcohol Services to respond to adult survivors of childhood sexual abuse. The 'problem identification' component of the action research approach was identified through the data.

Communities of Practice (CoP), which are an effective way to share knowledge, acquire skills and develop collaborative ways of working were developed in this phase and formed the basis of the action research process. The development of the CoP was an organic process in each area and guided and supported by the researchers.

At the heart of a CoP are three structural elements:

1. A domain which engages a group of individuals who are committed and engaged with the subject (responding to adult survivors of childhood sexual assault).
2. A community which binds itself together through the quality of relationships and ideally reflects the diversity of approaches and experiences required for leading edge innovation.
3. Practice developed in each community by sharing the knowledge of practitioners including the repertoire of tools, frameworks, methods and stories.[9]

The centrality of practitioner experience is acknowledged through the Community of Practice (CoP) approach.

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[8] Straus, Tetroe, & Graham (2011).

[9] Snyder & Wenger (2004).

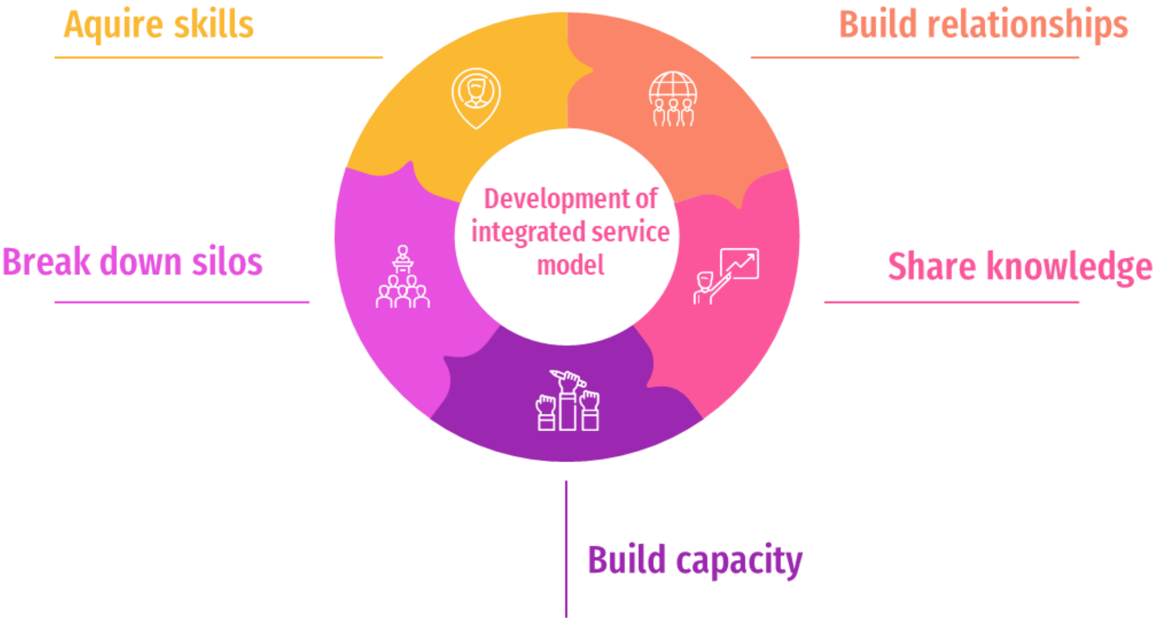


Figure 5: A Community of Practice

Stage Three: Action research – development and evaluation of local integrated service models

Participants in the Communities of Practice (CoP) at each pilot site met regularly to develop, trial and evaluate new integrated ways of working using an action research approach. This type of approach differs from a traditional evaluation in that the evaluation is integrated into each phase of the action research cycle, incorporating ongoing program development and focusing on promoting successful service response outcomes. The workers involved in trialing ways of working with adult survivors were asked to reflect and review approaches as they developed through the CoP meetings.

The research team worked alongside the CoPs to support the process, providing guidance and support, investigate changes in worker practices, and elicit data that highlighted practical changes and developments in the practice responses. The researchers worked ethnographically with the CoP to observe and document the practice developments. Each action research cycle consisted of planning, action, observing and reflecting.

Figure 6: The action research cycle

It was anticipated that throughout the ASP Research Project, three key action cycles would occur. The diagram below reflects how these cycles would inform each other in an iterative way.

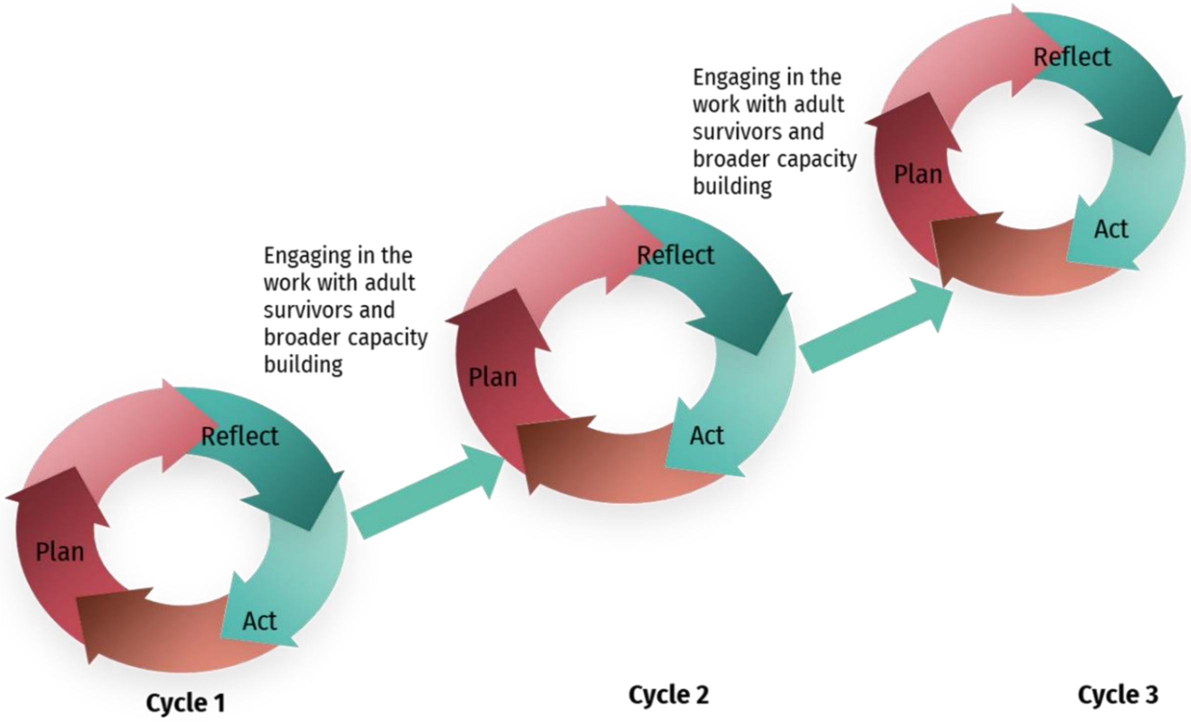


Figure 7: Action research iterative cycles

Stage Four: Consolidating learnings to inform state-wide implementation of the Adult Survivors Program

Stage Four synthesized data and findings from Stages One to Three to produce this final paper highlighting key learnings from the pilot sites and recommendations for appropriate and effective service responses for adult survivors. This report was produced using co-design with key stakeholders at each site. Specifically, the researchers considered the following factors when collating the triangulated data:

- leadership,
- senior management support,
- infrastructure,
- organisational culture,
- training, workforce development,
- collaborative approaches,
- an understanding of trauma-informed approaches,
- engagement with survivors,
- cultural safety and appropriateness of the service for Aboriginal people, families and communities,
- inclusiveness of the service, and
- inter/intra-agency collaboration.

All parts of the iterative action research led to knowledge creation to be used as a basis for practice-led policy development.

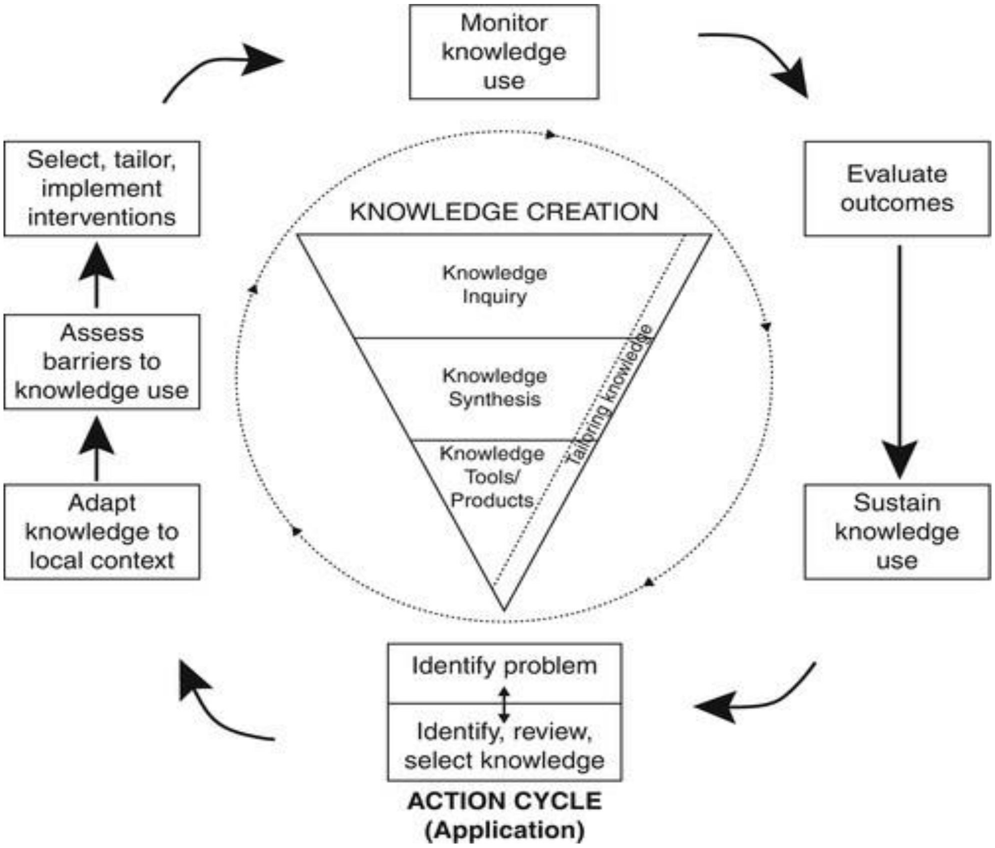


Figure 8: Source: Graham et al., 2006, Knowledge creation through action research

Section three: Methodology and data collection

1. Overarching research questions

The overarching research questions below were explored in the context of agency function, statutory responsibilities, disciplinary knowledge, policy mandate and interdisciplinary and interagency collaboration. The aim was to identify how workers in each service sector respond to adult survivors when they present with a number of health and welfare issues, identify examples of collaboration and/or conflict between agencies, explore barriers to collaboration, and generate ideas for areas of collaboration and integrated responses between the sectors.

Stages One and Two examined the following questions:

- How do workers in each of the service sectors conceptualise and respond to adult survivors of childhood sexual assault when they are faced with co-occurring issues?
- What are the current situations where there is collaboration between agencies and the processes and factors that contributed to collaboration working or not working?
- What are the barriers to successful collaboration?
- What are the training and capacity building gaps and needs?
- What are the local suggestions, ideas and current practices that will provide the basis to inform co-ordinated responses between the three sectors?

Current collaborative initiatives from the broader sector (identified in the literature review) were explored for their applicability in the local context.

Stage Three explored:

- How do workers, as part of case management, community development and broader capacity building initiatives assess and manage the complexity of the intersections of Sexual Assault, Mental Health, and AOD with survivors of childhood sexual assault?
- What formal collaborative arrangements are required for workers and their organisations to work with adult survivors?
- How does the survivor's voice influence the responsive work?
- Which staff are able to provide a specialist response and what are their training and capacity needs?
- What are the training and capacity building needs for the broader Health sector to best respond to adult survivors?
- How are priority populations thought about in service provision? How is the service model being developed for these cohorts?
- What are the issues for Aboriginal people and communities? How do we assess what a culturally safe and responsive service may look like physically and from a practice lens?
- How can a trauma-informed approach build common understandings and integrated responses to survivors, regardless of their point of presentation?
- How does practitioner-led service development translate into policy development?

- Client experience: is the model viewed as useful, acceptable and appropriate? How has it supported and assisted the adult survivor in their healing journey (i.e., appropriately and successfully addressing the client's trauma impacts)?
- Implementation: is the model being delivered as planned?

2. Ethics approval

The researchers met with the Ministry of Health Human Research Ethics Committee (HREC representatives to ascertain which elements of the evaluation approach would require HREC approval in accordance with the National Health Medical Research Council (NH&MRC) *National Statement on Ethical Conduct in Human Research* (2007), and the Policy Directive Research – *Ethical & Scientific Review of Human Research in NSW Public Health Organisations*, and which project stages would be categorised as a service improvement project. The Principal Policy Officer in the Research and Governance Office, Ministry of Health, provided staged guidance to submit an ethics application for the pilot. In response the researchers submitted an application to the HREC for Stage Three of the Pilot, the action research stage. This stage of the project was determined to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007) and was approved without any changes being made.

As the initial EOI submitted by the Mid North Coast Local Health District (MNCLHD) indicated that the district would endeavor to develop and trial an Aboriginal-led model of care and service delivery, guidance was sought around applying for Aboriginal Health and Medical Research (AH&MRC) ethical approval. CLT Byron worked closely with both the MNCLHD ASP Local Project Team as well as the research team's Specialist Aboriginal Cultural Consultant to submit an initial application to the AH&MRC. The AH&MRC HREC provided critical feedback and guidance on the application, and in response, the CLT Byron Consulting team worked closely with the MNCLHD ASP Local Project Team to develop the response and progress the application for approval.

Due to the changing context of the pilot, changes in staffing, moving the site of the pilot (from Kempsey to Coffs Harbour), issues of local governance and management, and time considerations, the decision to withdraw the AH&MRC application was made by the site, the Ministry of Health and the research team. The main rationale was that while AH&MRC approval was initially required to evaluate an Aboriginal-led model of care in Kempsey, the NH&MRC ethics approval that has previously been secured to support the research and evaluation at both pilot sites, would still allow for meaningful engagement with Aboriginal staff and stakeholders in MNCLHD and would reflect the shift in focus to establishing the pilot site in Coffs.

In response, the research team ensured that the five key principles for working with Aboriginal workers, families and communities developed by the AH&MRC and outlined in the document *NSW Aboriginal Health Ethics Guidelines: Key Principles* were kept at the center of the research approach. In addition, the research team ensured that the following strategies were employed to ensure cultural safety:

- Ensuring that the Aboriginal specified questions in the NHMRC application were central to the co-design of local data collection tools, analysis of data and final write up of the research findings.
- The Aboriginal Specialist Cultural Consultant from CLT Byron Consulting played a more extensive role in the action research process, for example, co-facilitating the Community of Practice in MNCLHD and undertaking additional interviews as required.

- The Specialist Aboriginal Advisory Group that was established by MNCLHD in Coffs Harbour contributed to and guided the research, ensuring it was safe for the Aboriginal workers involved.

3. Data Collection

Through the action research process, a range of both qualitative and quantitative data was collected from multiple sources, which was then triangulated to build up a picture of how the local service delivery approach was developed at each pilot site. This rich data provided information about 'how' services were operating through depth of description that described the complexity of the work.

The researchers worked ethnographically with the sites to document the new practices and the development of the new service response, capturing the essential elements of the local approaches, the challenges of this type of iterative development work, and program successes and challenges. The specific type of data that was collected was developed through a co-design process with the project team as each local site, responsive to local need and capacity. Local site-specific evaluation plans identifying local data to be collected were developed.

Overarching primary data collected across the two sites included:

- Local Stakeholder consultation sessions (Stage One) verbatim notes.
- HREC and AH&MRC applications, feedback and responses (Stage One).
- Community of Practice verbatim notes.
- Community of Practice monthly participant reflections.
- ASP Local Project Team weekly practitioner reflections.
- Additional Community of Practice communication and feedback.
- Meeting minutes from ASP Local Project Teams (management meetings, team meetings, staff meetings).
- Local Advisory Group presentations and minutes.
- Internal LHD service development meetings and minutes.
- Local LHD reporting and data.
- Client data collection.
- Trauma-informed reflective template submissions.
- Community of Practice reflective consultationsession verbatim notes.
- Individual Stakeholder In-depth Interviews.
- Partnership, training, and capacity building reports.
- Researcher ethnographic documentation and reflections.
- Survivor engagement plans and capacity building reports.
- Project plans, research plans, and service model development documentation.

Secondary data included an analysis and incorporation of:

- project evaluations,
- policy documents,
- internal NSW Health data,
- Royal Commission Reporting,
- current literature including approaches to working with adult survivors and AH&MRC suggested documentation.

Across the two sites the primary data included:

Method of data collection	Site 1: SESLHD data	Site 2: MNCLHD data	Total across the two sites
Key stakeholder consultation sessions (Stage 1)	3 consultation sessions	2 consultation sessions	**5 Key stakeholder consultation sessions**
HREC applications	1 HREC application and approval (covering both sites)	1 HREC application and approval (covering both sites) 1 extended AH&MRC process	**2 ethics applications**
Monthly Community of Practice (CoP) meetings	10 CoPs and verbatim notes	5 CoPs and verbatim notes	**15 CoPs and verbatim notes**
CoP summary used for iterative service development	9 summary pieces	4 summary pieces	**13 summaries used to support the iterative service development**
CoP participant reflective consultation group	1 CoP participant reflective consultation group	1 CoP participant reflective consultation group	**2 CoP participant reflective consultation group**
CoP participant reflection template	66 completed CoP participant reflection pieces	19 completed CoP participant reflection pieces (plus additional email feedback and communication)	**85 CoP participant reflection pieces**
ASP local project team practitioner reflection template	75 completed reflection pieces	9 completed reflection pieces	**84 completed reflection pieces**
Additional CoP communication	5 additional communication pieces with the CoP participants with feedback mechanisms	3 additional communication pieces with the CoP participants with feedback mechanisms	**8 additional communication pieces with the CoP participants with feedback mechanisms**
Meeting minutes from research team meetings held with the sites (project and research progress and management)	66 meetings	71 meetings	**137 meeting minutes and notes**
Advisory Group presentations and minutes	SESLHD Adult Survivor Advisory Committee meetings: 5 meetings	Initial implementation group meetings: 2 meetings Aboriginal Specialist Advisory Group: 4 meetings	**11 Advisory Group/Implementation group meeting's presentations and minutes**
Internal LHD service development documents and local reporting	• SESLHD Monthly Project Status Reports • Quarterly presentations provided to the SESLHD Advisory committee • Project Charter 2021	• Aboriginal Mental Health &AOD team Model of Care document • KPMG recorded meeting notes	**18 types of additional reporting pieces**

	- Communication Plan 2021 - SESLHD Stakeholder Consultation Report 2021 - 2020-21FY MOH Report - Consumer Participation Strategy 2021 - Consumer Participation Implementation Plan 2021 - Project Team Reflection data - 2021-22FY (February 2022 Update) - Consumer Participation Report 2022 - Workforce Development Report 2022 - Training & Capacity Building Report 2022	- KPMG Model of Care development consultation notes - Draft versions of the Model of Care - Internal correspondence and consultation for the Model of Care - Capacity building and community engagement table - Internal reporting	
Client data collection	Client data table (Total = 42 clients)	Client work tool (Total = 7)	**49 client examples**
Case studies	1 comprehensive case study	1 comprehensive case study	**2 case studies**
Other	Notes from research team half day workshop with clinicians (face to face)	Notes from meet and greet and re-connect meeting in Kempsey (face to face).	**2 additional sets of notes from workshops.**

4. Data analysis

Analysis of the data was a continual process throughout the research. As action research is iterative in its nature, the researchers would collect data from month to month, undertake a thematic analysis of that data and then feed it back into the service development approach through each site's Community of Practice and regular meetings with the ASP Local Project Teams. In this way the knowledge was built progressively through reflection and discussion, including a stakeholder feedback loop.

The developmental work occurred at two distinct levels:

1. Practice level: the ASP Local Project Team worked through the act/plan/reflect cycles for all of their work activities to ensure an iterative approach with survivors' voices at the centre of all decisions made.

2. Community of Practice (CoP) level: Each monthly CoP worked through the act/plan/reflect cycle to stay focused on the iterative development of the service. The ASP Local Project Team undertook the work or the 'action' between the 'research' (monthly CoP meetings and other data collection methods) and brought the outcomes of that work to the next CoP where it was discussed, and worker feedback captured. The feedback was captured in the meeting as well as through practitioner reflections that were sent after each meeting to allow more time for thought and consideration. The feedback was then looped back into the action (the service development). The diagram below shows the iterative nature of

the CoP meetings and how data collected each month fed into the next month's research cycle. Running alongside this process was the survivor participation strategy development work and findings that fed into the process.

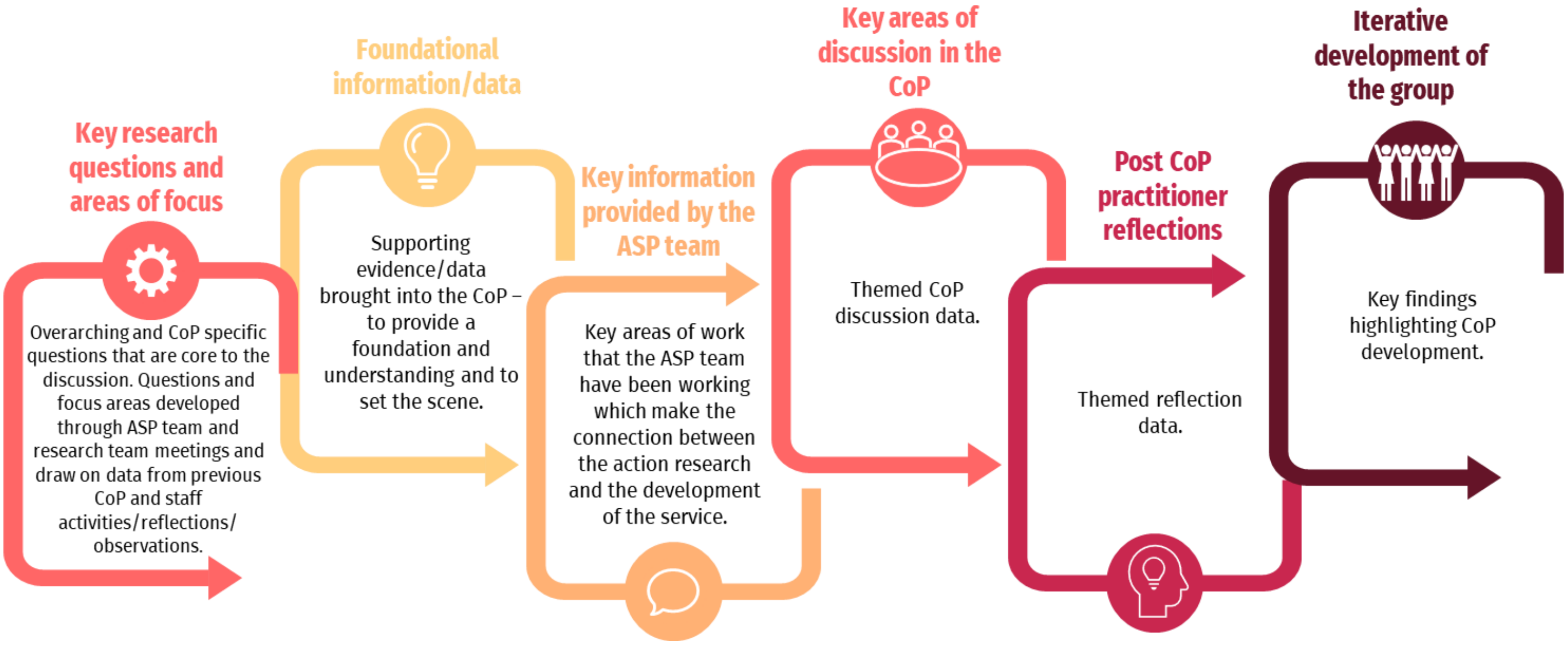


Figure 9: Iterative data analysis

All additional qualitative data (particularly the reflective pieces) were collected and analsyed using NVIVO, which is a qualitative data analysis software program, to determine themes and key findings. The CoP verbatim notes were also analysed overall at the end of the research in NVIVO to triangulate the data and build a picture of the work to respond to the overarching research questions of conceptualising and responding to adult survivors in the context of complexity.

Section Four: Developing a service for adult survivors at Site 1- South Eastern Sydney Local Health District (SESLHD)

1. Contextual considerations

Geographical context

South Eastern Sydney Local Health District is one of the largest local health districts in Sydney, covering a geographical area of 468 square kilometres from Sydney's central business district, the beaches from Bondi to Cronulla and down to the Royal National Park. The LHD delivers health care to around 930,000 residents across the local government areas of Woollahra, Waverley, Randwick, Bayside, Georges River and the Sutherland Shire. The area is home to a diverse population which is set to increase to 1,022,000 by 2031 (10% growth). In the community, 30% of people are from non-English speaking backgrounds, 37% have long-term health conditions, around 12,000 identify as being Aboriginal and around 20% of those identifying as homeless on census night were in SESLHD.

The impetus for inclusion to apply to be a pilot site was in response to the gap in service provision for adult survivors in the district and the challenges in providing integrated care for people with complex needs across mental health and drug and alcohol services and other partners such as St Vincent's' Health Network and non-government agencies. The LHD wanted to collaborate with local partners to establish an innovative response to adult survivors led by survivor voices.

Connection and integration work with Aboriginal communities

The ASP Local Project Team ensured that they took the lead from their Aboriginal colleagues in the district to ensure respect and appropriate engagement during the project. This included consideration of:

Culturally appropriate timeframes

The ASP Local Project Team's Aboriginal Health colleagues were able to provide guidance around appropriate and respectful time frames for engaging with local Aboriginal services, workforce and communities. The majority of consultation work was embedded in the wider SESLHD Sexual Assault Services Aboriginal Action Plan (AAP) processes. It was agreed that the ASP Local Project Team would not engage in additional and separate consultation and requests on local communities, to allow the time needed for this broader consultation. The site respected and prioritised this information and only engaged in work alongside the Sexual Assault Services AAP, as guided by the SESLHD Aboriginal Health Unit, during the life of the pilot.

Representation and engagement

The SESLHD Aboriginal Health Unit had ongoing involvement in project, including recruitment of the project lead; Advisory Committee representation; consultation throughout the project on a variety of matters and development of the Aboriginal Wellbeing Support Worker position (see additional details below).

Recruitment/Aboriginal Identified positions

The development of the Aboriginal position on the team occurred in consultation with the Aboriginal Health Unit in alignment with the Sexual Assault Services Aboriginal Action Plan. After significant consultation, the original 1.0 FTE Aboriginal identified position (Grade 1-2) has had the following changes: the position has been re-graded to a multi-class role (Level 1/2 and 3), the role has been expanded to a total of 1.2 FTE across 2 gender specific roles (male and female) holding 0.6 FTE for each role, the roles have approval for permanent recruitment, and a consulted working title has been established as Aboriginal Wellbeing Support Worker. Review and updating of the Position Description was undertaken with the Aboriginal Health Unit. This includes the delivery of cultural supervision provided by an Aboriginal consultant and a clearly articulated connection to the Aboriginal Health Unit to provide cultural safety and support.

Covid-19 impacts

The project's commencement coincided with the Covid-19 pandemic, and as such, contingencies were made including preparing for online meetings and flexible work practices. The changing nature of the pandemic impacted the project in different ways. These included:

- The ASP Local Project Team were required to work from home for lengthy periods with significant uncertainty. Extended lockdowns in Sydney meant the team engaged in a work from home model and online client work. The team were able to maintain the daily work and cohesiveness of the project. This was a substantial commitment and achievement for all team members, especially as there was increased COVID-related stress during this time.
- Staff Redeployments - over the course of 2021-22, two staff members were redeployed for several months to COVID-19 roles to assist the wider Health system.
- During this time, and especially during the lockdown periods, interagency and non-government organisation engagement activities were limited. As a result, people with disabilities, homeless services, young adults, care leavers and other groups that had expressed interest in participating were not as strongly involved as had been anticipated. The site will build on established connections to re-establish these relationships in the Implementation phase.
- Overall, there was reduced service capacity which limited some stakeholder participation as some services withdrew from all commitments that were not directly related to pandemic response client services.

Despite these challenges, there was continued and ongoing engagement with services and clients using online (virtual) communication.

2. Stage One: Consultation, scoping, and engagement

There were a number of significant outcomes in Stage One of the ASP Research Project at Site 1. These included:

- Identifying stakeholders to participate in action research, service development and evaluation activities.
- Mapping the local context and service system for adult survivors of childhood sexual abuse.
- Developing an understanding of how different service sectors conceptualise and respond to adult survivors of childhood sexual abuse when they are faced with co-occurring issues.
- Understanding facilitators and barriers to collaboration and integration in the South Eastern Sydney geographic area.
- Identifying training and capacity building gaps and needs.
- Exploring suggestions, ideas and practices that could be used to inform integration and support a locally specific model of coordinated responses to adult survivors across sexual assault, mental health and drug and alcohol services.
- Supporting orientation, development and action planning for new clinicians within the pilot service.
- Establishing governance processes and structures for the pilot project.
- Commencing recruitment of Community of Practice members.
- Ensuring survivors' voices were central to the process.

Establishing a working relationship with the Local Health District

The approach to the research team establishing a working relationship with the Local Health District, was staged and involved a number of strategic meetings and consultations. Developing a trusting and transparent relationship between the research team, the ASP Local Project Team and key local stakeholders at the site was critical to begin the partnership-based approach to service development. In addition to formal weekly project meetings and key stakeholder meetings, the research team had ongoing informal contact with the ASP Local Project Team in order to support the set-up phase of the pilot service and provide guidance and additional support to manage unexpected challenges or issues that arose through the set-up process. A site-specific research plan was co-designed with the site.

It must be noted that the work of the Local ASP Project Manager and Clinical Coordinator were critical in these initial stages of the ASP project. The Project Manager ensured the following operational tasks were undertaken, which provided the basis or 'starting point' for the development of the new service - the fit out of the new office location, recruitment of a project team, initial establishment of key stakeholder relationships, providing a strong link and connection with the research team, and developing reporting and documentation. The Clinical Coordinator ensured the day-to-day functioning and clinical development of the ASP Local Project Team, ongoing recruitment for remaining positions, development of ongoing partnerships, advocacy work with internal and external partners, and establishment of a strong collaborative working relationship with the Project Manager. The details of workforce development can be found in the *SESLHD Adult Survivor Project Workforce Development Report,* developed by the SESLHD ASP Local Project Team.

Survivor/consumer participation

One of the key principles underlying the action research approach was keeping survivor's voices central. The research team supported and provided advice on the site's involvement of survivors/consumers in the ASP project. A number of discussions were held to develop the key components of a site-specific consumer participation strategy. The work drew on *The Adult Survivor Pilot: Consumer Participation and Co-design Capacity Building Report*. The ASP Local Project Team consulted leaders within the sector to develop a robust and trauma-informed policy to guide the work and provide a considered approach to the needs of adult survivors. They developed two key documents to guide consumer involvement: the *SESLHD Adult Survivors Project: CONSUMER PARTICIPATION STRATEGY* and the *SESLHD Adult Survivors Project: CONSUMER PARTICIPATION OPERATIONAL PLAN.*

Key Stakeholder mapping and engagement

Initial foundational work

The ASP Local Project Team prioritised partnership development through a process of stakeholder mapping and then engagement. In this initial stage, key stakeholders were identified as: Sexual Assault Services, Aboriginal Health, Alcohol and other Drug Services and Mental Health Services who had been part of EOI application. This approach drew on support from SESLHD senior leadership.

Using recruitment to engage stakeholders

Executive level involvement in the assessment and appointment of project positions was a way to build and strengthen initial partnerships across the sectors. Strategies to bring the sectors on board included: recruiting from key Mental Health, Alcohol and other Drug, and Sexual Assault Services, using key stakeholders from those sectors expertise to contribute to the development of the position descriptions and as panel participants to select successful employees. Initial positive impacts of this approach include project buy in from across the service sectors and the development of stronger collaborative relationships.

Internal SESLHD Stakeholders and developing a governance structure

A working group of senior representatives from the key service sectors (Sexual Assault Services, Aboriginal Health, Drug & Alcohol and Mental Health Services) met to develop the expression of interest and drive the early implementation of the project prior to the establishment of a formal SESLHD Project Advisory Group.

Consultation and support at this stage ensured a successful establishment of the formal Advisory Committee that included representatives from:

- Population and Community Health
- Child Youth and Family Services,
- Mental Health Services,
- Drug & Alcohol Services,
- Sexual Health & Blood Borne Viruses,
- Aboriginal Health Unit,
- Integrated Care St Vincent’s Health Network,
- Allied Health Services, St Vincent’s Health Network,
- Wayside Chapel,
- Peer Support Mental Health Services, and
- The Program Delivery Office, Government Relations Branch, Ministry of Health.

This group provided an essential authorising environment to oversee and support the iterative development of the service.

Identifying and engaging non-government organisations

The site developed a comprehensive list of Non-Government Agencies using the ASP Local Project Team's knowledge and relationships to draw on their expertise in the areas of Domestic Violence, Mental Health, Alcohol and Other Drugs, and Sexual Assault as well as other relevant NGOs. There were 60 relevant NGOs identified. A snowball methodology was used - those identified NGOs were invited to forward information about participation in the ASP project to other agencies and organisations they thought appropriate to develop a broad network.

Stakeholder consultations

Three broad consultation sessions were facilitated by the research team between October 2020 – February 2021. The aim of these consultations was three-fold: to bring about awareness of the ASP project in SESLHD to organisations outside of NSW Health, to explore the research questions looking particularly at facilitators and barriers to service provision for adult survivors, what is available in the local area and where are the gaps, and to raise interest in development of the new service through participation in the action research process. Participation included representation from the following service delivery contexts:

- Child protection
- Aboriginal Health
- CALD and Refugee services
- LGBTQI+ services
- VAN (including sexual assault services)
- Domestic and Family Violence
- Education
- Disability
- Homelessness
- Alcohol and other Drug
- Mental Health
- Community Centres

The consultation discussions provided local expertise on the needs of survivors in the local area and provided a foundation on which the service could have as its starting point. The data set collected from the consultations was used as a basis to drive the iterative service development and are reported in the key findings section of this report.

Outcomes of the stakeholder engagement and consultation process (Stage Two)

The outcomes of the stakeholder engagement, scoping, and exploring informed the next phase of the project (Stage Two) and included:

- Confirmation of the issues facing adult survivors of child sexual abuse in the South Eastern Sydney area which were consistent with the current research and Royal Commission findings.
- Developing an understanding of the local service sector context in which the pilot would be situated.
- Using local expertise and knowledge to develop an understanding of local service issues.
- Developing widespread support and interest in the project.
- Developing support and key relationships developed for the establishment of the project's governance.

- Enhancing a strong working relationship with the ASP Local Project Team and the research team.
- Supporting opportunities for early partnership work in the project.
- Initial recruitment of Community of Practice members.

3. Stage Two: Developing the SESLHD Community of Practice (CoP)

Building the Community of Practice (CoP) used a two-pronged approach: a ‘bottom up’ and ‘top down’ strategy. The ‘bottom up’ strategy allowed for local services to self-identify and choose to participate. The ‘top down’ approach involved all members of the SESLHD ASP Pilot Project Advisory Group nominating two workers from their service sector to be part of the CoP.

The stakeholder consultations highlighted an interest and enthusiasm for the pilot project. All of the SESLHD services who attended the consultations went on to participate in either the ASP project governance group or to nominate staff from their services to be part of the Community of Practice. Of the NGOs who participated, 9 services self-nominated to be a part of the Community of Practice going forward, with many of the remaining services expressing interest in participating in future consultations and supporting the ongoing work of the ASP Project.

SESLHD Community of Practice: Participation summary

The following services formed the SESLHD Community of Practice:

SESLHD services	Other Health services	Non-government organisations
Adult Survivor Pilot Team Sydney Sexual Health Centre Early Psychosis Program, Eastern Suburbs Mental Health Service Kirketon Road Centre Kiloh Centre, Eastern Suburbs Mental Health Service Assertive Community Management Team, Drug and Alcohol Service Drug and Alcohol Service Child Protection Counselling Service Sexual Assault Service Perinatal and Infant Mental Health Service Acute Care Team, Eastern Suburbs Mental Health Service	Central Metropolitan Joint Child Protection Response Program Child Protection Unit, Sydney Children’s Hospital Social Work Department, St Vincent’s Hospital Assertive Community Management Team, St Vincent’s Hospital	Crossroads Community Centre Wayside Chapel Advance Diversity Services Stepping Out The Gender Centre Resilient Families, Benevolent Society Survivors and Mates Support Network ACON Domestic, Family and Sexual Violence Service Women’s and Girls Emergency Centre Family Connect and Support Services, Barnados

Psychology Department, Prince of Wales Hospital		
Total number of services represented: 25		
Total number of participants: 40		

The following table highlights SESLHD (Site 1) Community of Practice participant numbers throughout the action research process to October 2021:

Community of Practice	Number of participants	Additional reflections received
Meeting 1: February	19	11
Meeting 2: March	26	10
Meeting 3: April	16	7
Meeting 4: May	21	7
Meeting 5: June	19	4
Meeting 6: July	24	11
Meeting 7: August	21	15
	The September Community of Practice was cancelled in consultation with the Community of Practice group, Adult Survivor Project Team, and SESLHD Senior Managers due to the impacts of COVID on the workforce.	*N/A*
Meeting 8: October	17	4
Meeting 9: November	14	2
Meeting 10: December	11	N/A

4. Stage Three: Using an action research approach to develop a new service

Describing the development of the service through iterative action research

The iterative developmental work occurred at two distinct levels at SESLHD (Site 1). As described in the data analysis section this was at (1) the practice level and (2) the Community of Practice (CoP) level. As site 1 undertook the action research stage for 12 months they were also able to participate in broader action research cycles which occurred every three months where with the researchers and participants explored exploring what had happened over the last three months (the acting and observing), reflecting on that work and how the service had been developing, and planned for the next three months. The diagram below illustrates the broader cycles.

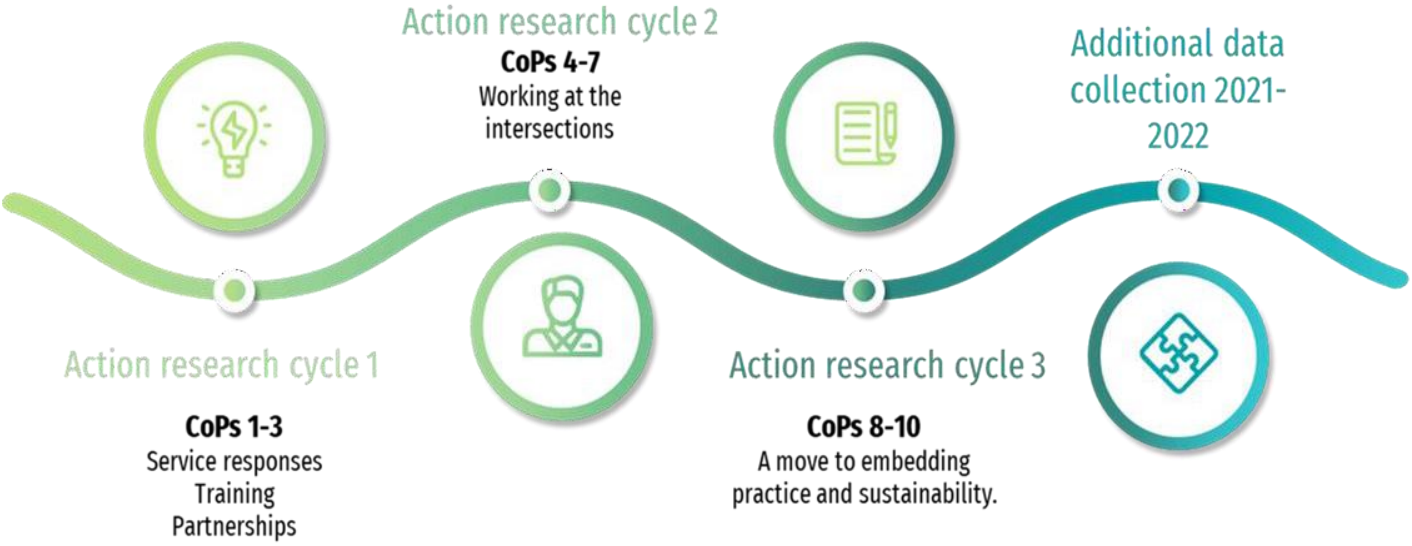


Figure 10: The focus of each broad action research cycle at Site 1

Overview of the Community of Practice Meetings

CoP 1: Establishing the Community of Practice and developing components of effective service delivery for adult survivors.

The key focus of the first CoP was to introduce the project, provide an overview of the action research process, explain the role of the CoP, and provide feedback collected from key stakeholders in South Eastern Sydney in Stage One of the project, to provide a foundation for discussions about how to start to develop a new integrated service for adult survivors. The feedback included: gaps and challenges for services working with adult survivors, key messages for effective service delivery and ideas about what a new service could offer.

The key discussion points included a further exploration of services responses for adult survivors in the local context – gaps and opportunities as well as preliminary ideas for development of the new service in the SESLHD. These included:

- Collaboration with other services around specific clients (for example direct client work).
- Collaboration with other services around gaps in resources or capacity (for example co-working, consultation).
- Capacity-building workers (for example supervision, consultation, coaching).
- Sending a dedicated team member (for example having an ASP clinician co-located to work with another service, establishing specific referral pathways or 'clinics').

CoP 2: Developing effective partnerships

The key focus of the second CoP was on partnerships and how they could contribute to the development of an integrated service response for adult survivors. The CoP built on data from stakeholder consultation sessions and thematic analysis of reflections from CoP 1. The ASP Local Project Team also presented specific case studies around preliminary partnership work with other health services and NGOs.

The key discussion points included:

- Strong endorsement to develop the new service through partnerships.
- Partnerships as crucial to providing survivors access to flexible, creative support.
- Co-work opportunities with the new service.
- Benefits of a partnership approach as opposed to traditional ‘referring on and closing’.
- Need to develop a shared language around adult survivors and child sexual abuse.
- Barriers to partnerships at an individual, service, policy and cultural level.
- Capacity-building needs across the service system.

CoP 3: Training and capacity-building

The key focus of the third CoP was on capacity-building, training and workforce requirements. This CoP built on data from stakeholder consultation sessions and feedback from CoP participants in the previous meeting and reflections. The ASP Local Project Team presented preliminary ideas about training and the role of the new service.

The key discussion points included:

- Systemic training gaps across the system and lack of confidence responding to child sexual abuse.
- Need to support workers to expand practice beyond the medical model.
- Opportunities to learn from capacity-building work in child-focused services and the NGO sector.
- Potential to explore partnerships with the Education Centre Against Violence and My Health Learning.
- Going beyond training to look at flexible capacity building, influencing systems, championing and promoting good practice.
- Impacts for survivors of a better trained workforce: being less judged, not being shut down, being seen as a ‘whole person’, receiving a helpful response regardless of who they disclose to, and feeling confident to access services in times of need throughout their life.

CoP 4: Reflections on the first action research cycle and moving into direct client work

The fourth CoP focused on the transition between the first and second broad action research cycles, and considerations for the next stage of the service development (direct client work). The research team and ASP Local Project Team presented summaries of the respective work of the teams so far and invited feedback and reflective discussion around participant views of the process.

The key discussion points around the first action research cycle included:

- Goals of the CoP to develop the pilot and support wider systems change.
- Positive feedback around the CoP as a space to connect around a shared goal to improve responses to adult survivors.
- Reducing siloing between Health and NGOs.
- Keeping discussions ‘grounded’ and focused on direct practice / outcomes for survivors.
- Time, energy and resources required to support integration, including sitting with vulnerability and uncertainty.

The key discussion points around direct client work included:

- The need to explore new flexible ways of working.
- Being survivor-led requires challenging ideas of ‘eligibility criteria’ and ‘readiness’ to engage.

- Shifting services from ‘presenting issues’ (e.g., mental health, substance use, homelessness) towards ‘underlying issues’ (e.g., child sexual abuse, complex trauma).
- Capacity for the new service to provide consultation and support to other services.

CoP 5: Exploring the intersections: A focus on alcohol and other drugs

The fifth CoP focused on exploring the intersections of working with adult survivors where there is use of alcohol and other drugs. This focus was identified to support client work within the pilot service and respond to CoP participant feedback. The research team presented reflections on the work so far with the CoP and the ASP Local Project Team provided updates about their current scope of work.

The discussion was based on a case study presented by a CoP participant from a NSW Health Drug and Alcohol Service. The participant shared learnings from their engagement with survivors and work to develop a new program to support people using alcohol and other drugs with complex needs. The key discussion points included:

- The need to meaningfully connect childhood sexual abuse, substance use, and the non-linear nature of recovery.
- Gaps in services increase when survivors are perceived as ‘too complex’ or ‘in crisis’ (e.g., current substance use or in early recovery).
- Opportunities for ‘windows’ of trauma-informed support (e.g., brief interventions, crisis responses, practical support).
- Need for policies and business rules that support flexible, proactive engagement.
- Need for workers and services to sit with significant ‘risk’.
- Challenging traditional idea of alcohol and other drug use interventions (e.g., making safety and connection the target rather than reduction of use).
- Need for a coordinated ‘whole of Health’ response.

CoP 6: Exploring the intersections: A focus on mental health (Part 1)

The sixth CoP focused on exploring the intersections of working with adult survivors where there is use of alcohol and other drugs. This sat alongside updates provided by the research and ASP Local Project Team.

The discussion was based on a case study presented by a CoP representative from a Health Mental Health Service, sharing one survivor’s journey through the mental health system over a several year period. The key discussion points included:

- Tension between the power of the medical model and trauma-informed, survivor-led approaches.
- Ability of service responses to reduce or increase fragmentation in survivors’ sense of self.
- Keeping someone’s experiences of abuse visible and responding meaningfully (as opposed to documenting ‘history of CSA’).
- Flexibility within one service allows dovetailing with other services to offer integrated support.
- Importance of case coordination, advocacy and case management.
- Expanding criteria for effective intervention beyond symptom management and discharge from services.
- Interest in defining integration through the survivor experience rather than service integration.
- Opportunities for the pilot service to support systems change.

CoP 7: Exploring the intersections: A focus on mental health (Part 2)

This CoP marked the transition into the last broad action research cycle. A decision was made to continue the discussion from the sixth CoP, including responses to the previous case study from NGOs and Violence, Abuse and Neglect services to support a wider service sector lens. The research team and ASP Local Project Team presented summaries of reflections on the case study and implications for the pilot service.

The key discussion points explored relevant learnings for the new pilot service, including:

- De-pathologising survivor experiences of mental health.
- Understanding how survivors relate to services will reflect impacts of trauma and abuse in relationships.
- Key components of a wrap-around approach.
- Tensions between strengths-based vs risk management approaches.
- Resource allocation for individual workers to enable integration (particularly ‘indirect’ case management and collaboration with other services).
- Importance of attention to language.
- Idea that it can ‘take a village’ of services collaborating to provide integrated support.
- Role of peer support and survivor voice.

CoP 8: Centring survivor voices through consumer participation and work with survivors as advocates

The key area of focus in the eighth CoP was keeping survivor’s voices central across all aspects of service responses. This focus was identified based on the ASP Local Project Team’s progression in consumer participation following earlier consultation with the CoP and feedback in participant reflections. The research team also presented the visual journey of progression of the work to re-centre CoP participants.

The ASP Local Project Team presented a broad update around clinical work, capacity building, partnerships, and service development. This was followed by an in-depth presentation around learnings from the ASP Local Project team’s engagement with survivor advocates through a consumer participation strategy. The key discussion points included:

- Strong endorsement for the strategy.
- Ways to continue working with survivor advocates to make lived expertise part of the new service.
- Challenging rigid expectations of ‘consumer participation’ within Health services.
- Importance of the ‘detail’ in a flexible, survivor-led process of consumer participation.
- Sharing power, reciprocity, and restorative relationships i.e., professionals stepping outside the ‘expert’ role.

CoP 9: Consolidating the work: What is the core role of the Adult Survivor Service within NSW Health?

The key area of focus in the ninth CoP was in consolidating the work of the CoP and ASP Local Project Team, conceptualising the new service and learnings for statewide implementation. The research team presented a summary of the work of the CoP so far and next steps for the group. A representative from the Ministry of Health presented an overview of the plans for statewide rollout.

The ASP Local Project Team provided updates about their work and led a discussion conceptualising the role of the Adult Survivor Service within the broader service system.

The key discussion points around conceptualisation of the service included:

- Service design that responds to gaps in the current Health response to adult survivors.
- Developing a continuum of support between crisis services and longer-term ‘trauma’ services.
- Service design that recognises that recovery from abuse is non-linear and ongoing.
- Components of a flexible assessment, referral and response process.
- Sustainability of the model as key to meeting survivors needs.

The key discussion points around learnings for statewide implementation and policy development included:

- Ongoing communication between decision-makers, frontline workers and managers.
- Importance of authorising environment.
- Staff need to be supported to continue the integrative work.
- Broader integration between Health and NGO sectors.
- Opportunities for system-wide change e.g., universal training around child sexual abuse.

CoP 10: Wrap-up of the Community of Practice and key messages for continuation of the work in SESLHD and to inform statewide implementation

The final CoP comprised two sessions. The first session was a reflective consultation group led by the research team around key messages to inform both statewide implementation and continuation of the work in SESLHD. The second session was a wrap-up of the Community of Practice led by the ASP Local Project Team and discussion of next steps.

The key discussion points from the group were:

- Keeping survivor voices and journeys central in the service development.
- Acknowledging power structures within Health and other services.
- Key workforce capabilities for working with adult survivors.
- Power of effective partnerships and collaboration.
- Developing a shared language to support integration.
- Sustaining system-wide changes to improve survivor experiences.
- Learnings around cultural safety and engaging with Aboriginal communities.

The key discussion points from the wrap-up discussion were:

- Benefits of service development using an iterative/action research/Community of Practice approach.
- Time, energy, and resources required to do integration work.
- Importance of an authorising environments at every level.
- Working systemically to create change.
- Challenging harmful expectations and norms about adult survivors cross the Health system.

At the conclusion of the final CoP, the group discussed a plan to continue meeting as a Community of Practice within SESLHD led by the ASP Local Project Team and existing CoP members.

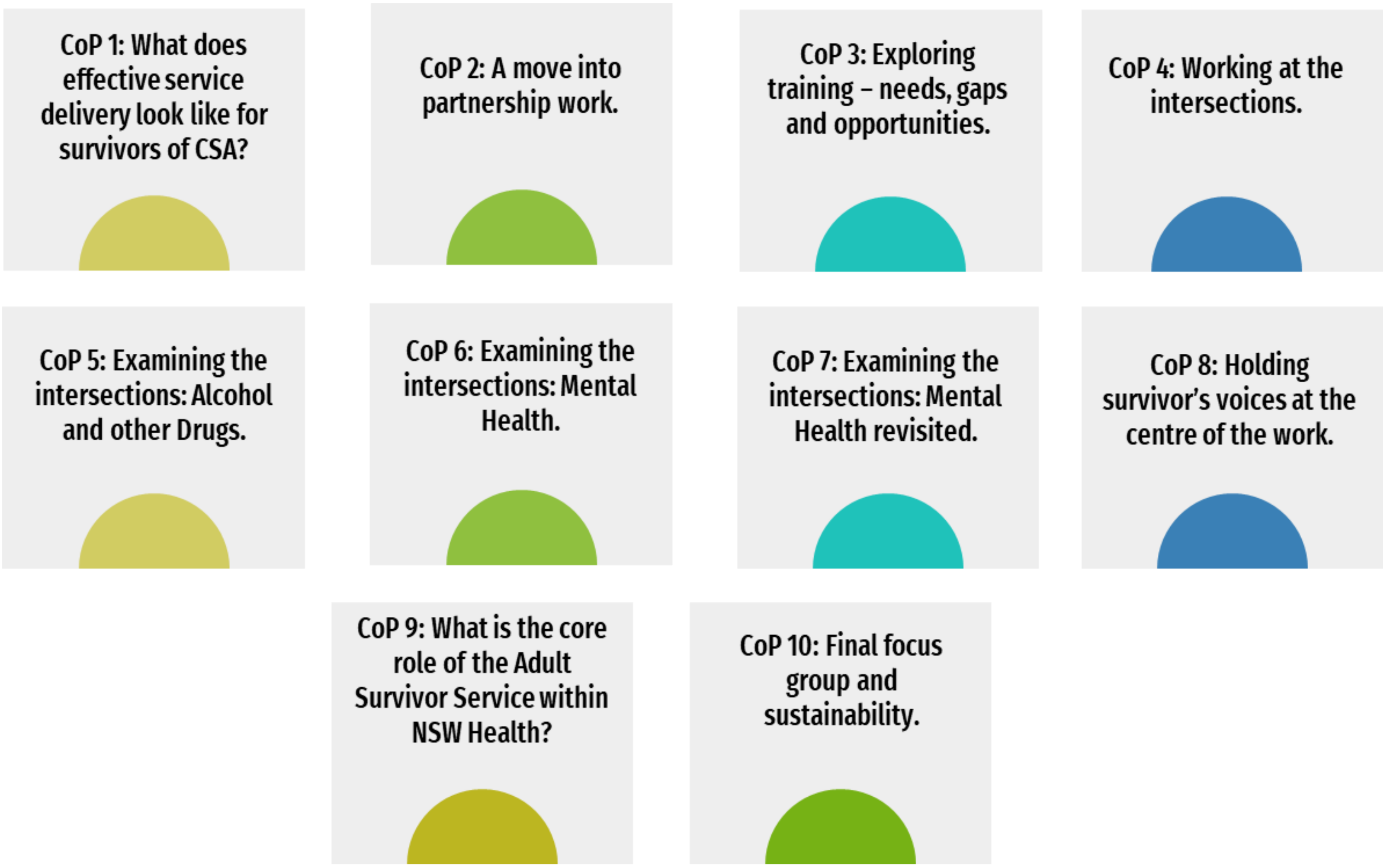


Figure 11: An overview of the iterative development of the service through the Community of Practice meetings at Site 1.

Outcomes for Site 1

The action research framework allowed the project team to work iteratively and provide client led clinical responses. There was flexibility to explore what survivors needed that was not otherwise provided in a health response. The diagram below reflects the bodies of work that the site achieved and continue to develop.

Figure 12: Core elements of service development at Site 1

SESLHD ASP Local Project Team conceptualisation of the development of their service response

1. They listened and responded

They listened to survivors (clients & consumer representatives), the Community of Practice, colleagues and the broader Health system about what worked and what did not work. The research framework allowed this exploration and foundation to shape the practical work of clinical service delivery.

2. A starting point: Client work was seen as an opportunity

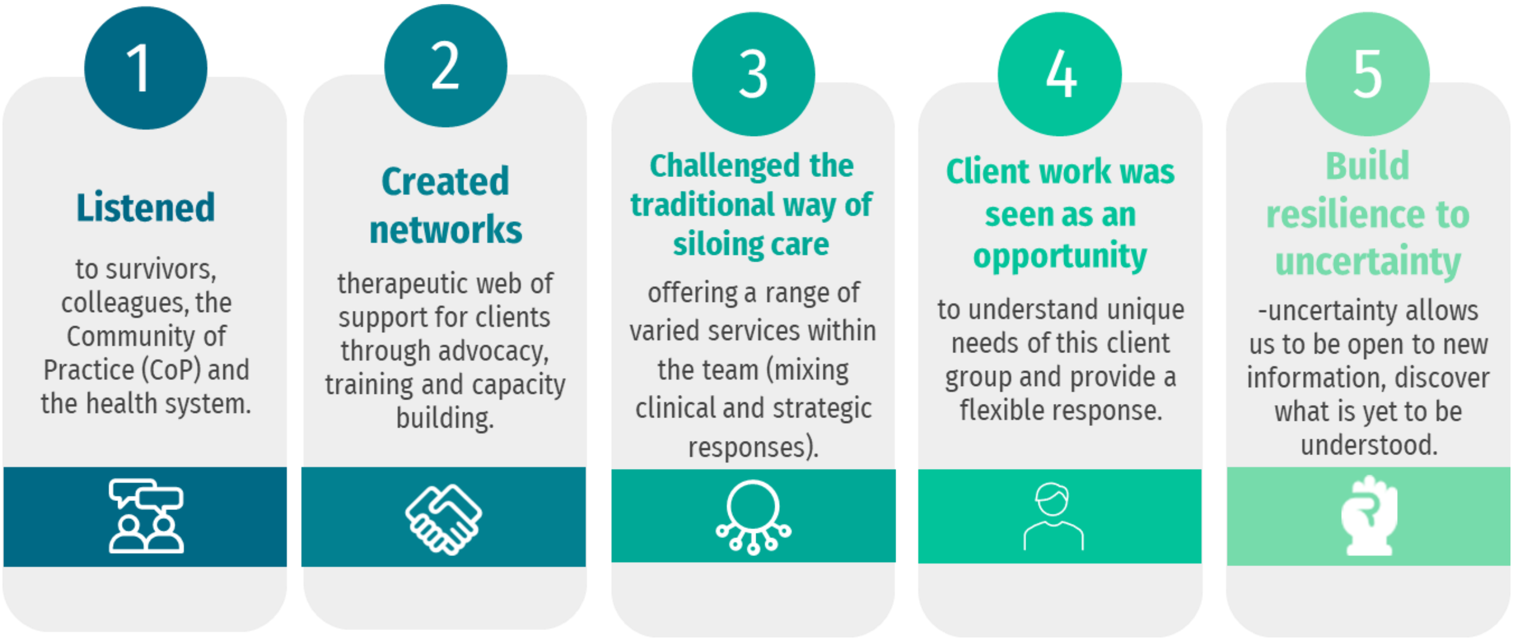
The team offered clinical referrals to clients who would otherwise not be seen in mainstream services or would have to wait extended periods of time on the sexual assault waitlist. This provided an opportunity to understand the unique needs of survivors and explore clients that may ‘fall through the gaps.’ They could also explore whether a flexible clinical response might be the most useful for this client group.

3. Keeping a trauma response at the centre

In the same way they de-siloed the team’s delegations (from specific ‘mental health’, ‘drug & alcohol’, ‘sexual assault’ specialties to ‘trauma clinicians’), the team needed to ensure they de-siloed the client’s experience of abuse as well as the service response to understanding of child sexual assault, beyond an incident-based sexual assault response. A trauma-informed response was essential to support and respond to survivors where cumulative trauma and intersecting issues (e.g., drug & alcohol & mental health issues) were a standard presentation.

4. Challenging the traditional way of siloing care

By using a trauma-informed approach, they were able to offer a range of varied services within the team, mixing clinical and strategic responses. Examples included extended early engagement, flexibility with missed appointments, short follow up contacts, support for Victims Services applications, linking with other services to assist with immediate needs, utilising team member’s expertise in mental health and drug and alcohol knowledge, liaison and support across different parts of the health service as well as therapy services. Each client was provided a flexible and uniquely tailored approach that supported them with their current presentation.



Listened to survivors, colleagues, the Community of Practice (CoP) and the health system.

Created networks therapeutic web of support for clients through advocacy, training and capacity building.

Challenged the traditional way of siloing care offering a range of varied services within the team (mixing clinical and strategic responses).

Client work was seen as an opportunity to understand unique needs of this client group and provide a flexible response.

Build resilience to uncertainty -uncertainty allows us to be open to new information, discover what is yet to be understood.

Figure 13: Conceptualisation of developing the new SESLHD service

A developing service model

The following section describes the process of developing a new service for survivors in SESLHD.

1. Understanding the two- part systemic response for survivors: finding a place for the new service

In doing this work, the ASP Local Project Team were able to unpack some of the systemic and unspoken expectations for referrals. They identified that the bigger system identifies two key areas of intervention or support:

1. Crisis Services	2. Therapy/counselling Services
This includes siloed services like Mental Health, Drug and Alcohol, Emergency Departments, crisis Sexual Assault Services and crisis Domestic Violence Services. The team knew a large proportion of clients who identified as adult survivors of childhood trauma utilise these services. These responses were often short term and addressed immediate 'one-focused' needs. It was then expected that clients will then move onto therapy/ counselling services.	Clients would then be expected to move onto 'talking' therapies to assist in their trauma recovery. Services generally worked with 'different parts of trauma' further fracturing the client's experience.

2. What a two- part response means for adult survivors

A standard health care response assumes that a short-term crisis service can stabilise clients sufficiently to be able to refer them into longer term counselling, in a linear way. This can work for many people however adult survivors often experience cumulative trauma and have multiple presenting issues. Siloing service interventions, therefore, requires clients to be able to seek support for different parts of their trauma and 'presenting issue' rather than experience a service that integrates all of the person's trauma and challenges. The clinical work of the project found that trauma clients are rarely stabilised enough at the conclusion of crisis services to be able to engage in trauma therapy (particularly if it is in a siloed format) and they are then at high risk of cycling back into crisis services.

3. A new type of response: the service between crisis and counselling - Integrated stabilisation and support

The ASP Local Project Team were able to provide uniquely tailored support that offered a 'middle space' between crisis and counselling services. They found the following:

- Clients and consumers have often said they want support but do not want to talk about their childhood trauma. They want support with current challenges and responses to their trauma that continue to get in the way.
- In many cases, clients had not made the connection between their childhood trauma and their current challenges therefore could not identify triggers for their trauma. This is often a barrier to then seek traditional counselling services that focus on a specific trauma recovery.
- Trauma recovery starts with building a relationship with a consistent person over a medium to long term period. Trauma occurred in a relationship therefore recovery needs to occur in a new safe relationship. Providing a service that is designed to offer stabilisation and consistency will reduce the cycle and dependence on crisis services, and support clients move toward possible trauma therapy.
- For some, a stabilising service response will be enough, and they may not choose to engage in trauma therapy.
- During the clinical work of the project, the stabilising work becomes the space for integration and allowing understanding of a holistic view of trauma. This meant that clients did not have to continue to access a number of different clinicians and services to get their needs met.
- There is evidence of where this model is working well in NGOs and some health services (e.g. Assertive Case Management Services in AOD and an NGO – Stepping Out), however these are not mainstream referral pathways for adult survivors.

Figure 14: The service space 'in the middle'

4. Continued work and exploration

The project engaged in 41 clinical referrals and have provided additional data about the type of flexible support provided. A clinical case study has also been completed as part of the research data. This is detailed in Section Six of this report. There is more work to be done to explore the experiences of the SESLHD Adult Survivor project and ongoing research support in this clinical arena would be very beneficial to developing a sustainable model of care for state-wide implementation.

Section Five: Developing a service for adult survivors at Site 2 - Mid North Coast Local Health District (MNCLHD)

1. Contextual considerations through the life of the project

Historical context

The MNCLHD is a diverse district with a very large geographical spread. The LHD is home to strong and resilient Aboriginal communities with 5.7% of the population identifying as Aboriginal and/or Torres Strait Islander. This is higher than the New South Wales average of 2.9%.[10] However, there are continued and ongoing impacts for Aboriginal people, families and communities living in the area resulting from forced removal. The children who were incarcerated at the Kinchela Boys Home from the 1920s to 1970s continue to experience devastating effects. The intergenerational trauma is also felt by the descendants and families of the those who were incarcerated and remains a significant issue.

This region has a strong community that is working towards redressing the past history of trauma. Health services have a role to play and are working at improving cross-sector service delivery and creating culturally safe services. However, this area faces the same challenges as other LHDs, working within historical siloed sectors and approaches and challenges occurred in the pilot when principles of service provision did not align.

Governance and leadership impacts

The site faced a change in leadership and in leadership structure at the commencement of the ASP project. When the EOI was submitted, Mental Health, Alcohol and other Drug, and Integrated Care Services came under the same Senior Executive Lead. By the time the project commenced, Senior Leadership of the portfolios was separated, and new directors were in each portfolio. The Senior Leadership of the Integrated Care Directorate changed once more across the course of the ASP Project.

Initial engagement in the submission of the EOI was built on excitement and anticipation of an Aboriginal designed and led model of care and the possibilities of how this could change service delivery and increase accessibility for Aboriginal people and community to a form of sexual assault service. With a rapid change of leadership and leadership structure the high level of commitment and interest that was evident on the EOI was not sustained. As a result, the authorising environment to support the work was lost.

Integrated services can take time when negotiating service principles, and support of developing something new may not be understood when existing supportive relationships change. Part of the understanding and commitment to the project was lost with changing executive sponsorship and changing pilot contact leads. In

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[10] https://mnclhd.health.nsw.gov.au/aboriginal-health/

addition, cross collaboration and integration between the two leading teams proved challenging, given the changes in service structure and reporting.

Workforce impacts

Throughout the life of the ASP Project there was considerable movement of, and changes in, staff involved in the project. The district found it difficult to recruit to the Adult Survivor Pilot positions, particularly the positions the site had designated as Alcohol and other Drug and Mental Health positions. Recruitment challenges included: a rise in housing prices in regional areas, staff burnout, districtwide staff shortages, diversion to COVID response, and furloughed staff.

Due to the limited and already stretched staffing environment, an outside consultancy company was contracted to lead the project through Stages One and Two, which led to successful project management but reduced the local and clinical expertise input in this critical stage of the pilot. This had a flow on effect that impacted local relationships across the district.

Natural disasters and Covid-19 impacts

At the commencement of the pilot, the MNCLHD had just emerged from severe bushfires which had significantly impacted communities across the North Coast of NSW. This was followed by significant flooding events which impacted staff availability and capacity. The pilot started at the beginning of the Covid-19 pandemic which limited scope, negatively impacting on recruitment of staff with many staff across the sectors (VAN, AOD, MH) experiencing 'Covid anxiety' (fear of working in the Health system).

2. Stage One: Consultation, scoping and engagement

Developing a working relationship with the LHD

An initial establishment meeting, or 'meet and greet' was facilitated by the Ministry of Health where the research team were introduced to the ASP Local Project Team. It was identified at this meeting that there were two sites to be developed in the district: Kempsey and Coffs Harbour. This approach was in line with the original EOI which aimed to develop an Aboriginal designed and led model in Kempsey that would be inclusive of the whole community. The learnings from the Kempsey site would then be used to guide the development of the service in Coffs Harbour. It was agreed that the pilot work would start in Kempsey and the Coffs Harbour site would follow. A temporary project manager was designated as the key contact for the site. The research team worked with the temporary project manager (the ASP Local Project Team Lead) in the initial stages of the ASP Research Project, developing a site-specific research plan and an understanding of the local context.

Stakeholder mapping and engagement

The stakeholder mapping and engagement was led by the ASP Local Project Team Lead. The researchers were guided by the expertise and advice of the local lead on how to engage with key stakeholders and what this should look like. It was conveyed to the research team that the site had been working on the following:

- Extensive engagement with internal stakeholders and positive external engagement.
- Liaison with Aboriginal organisations about cultural supervision and cultural healing groups.
- Development of a stakeholder map.

Working in partnership with the site, it was determined that some time had passed since the initial EOI was developed and an initial key stakeholder meeting and consultation session with key stakeholders at the site would be an appropriate way to re-introduce the project to key stakeholders, provide a background to the project and a brief of work to date.

Stakeholder Consultations

Two stakeholder meetings (consultations) were held. The following sectors from NSW Health services in MNCLHD were represented:

- Child Protection
- VAN (including sexual assault)
- Aboriginal Health
- Aboriginal Family Violence Prevention
- Mental Health
- Alcohol and other Drugs
- Domestic and Family Violence
- Aged Care and Chronic Disease

The consultation sessions included a discussion of the Royal Commission recommendations and NSW funding, a key focus on integration, the importance of developing an integrated model using practitioner knowledge, traditional difficulties of siloed approaches, development of a service that is culturally safe and robust which will be suited to the broader community and a review of the initial EOI. The sessions allowed the researchers to consult the key stakeholders on local context and current service provision, barriers and gaps for adult survivors, and enablers to working with survivors.

Outcomes of the stakeholder consultations

The key findings from the stakeholder consultations included:

- Conceptualising how services could be different for an adult survivor of childhood sexual abuse (particularly Aboriginal survivors) with the development of the new model.
- Conceptualising how things would be different for service providers with the development of a new model.
- Enablers or opportunities for a new service for adult survivors and the barriers which need to be understood and addresses to progress developing the new service on the Mid North Coast.

- Centring Aboriginal input and ownership of the knowledge as well as communication between the researchers and the ASP Local Project Team.
- Developing broader engagement strategies to encompass views of different communities and families.
- Acknowledgement of the significant community engagement work undertaken to develop an Aboriginal Mental Health and Alcohol and Other Drug Model of Care (wellbeing model) and an understanding of how that work was progressing in Kempsey. Discussions included how the adult survivor response could be leveraged off the current work being undertaken in Kempsey and how the collaborative approaches between mental health, alcohol and other drug and Violence, Abuse and Neglect services could begin.
- Discussion of the role of NGOs and other key stakeholders in the development of the model.
- Discussion of the two sites: what will happen where and who will be involved? There were differing understandings of this, highlighting competing priorities and possible tensions between the service sectors across the geographic area.

It became evident to the research team that there were competing priorities and tensions between the key stakeholders within the Mid North Coast Pilot site. The service sectors had differing understandings, philosophies, and approaches that were not currently aligned. It was also clear that new staff had not been recruited to any of the positions in the ASP Local Project Team. At this time, local staff holding other positions in the district had been given the responsibility to undertake the ASP Project work until permanent staff were found. It was clear that a strategy to support a ‘re-group’ and realignment for all stakeholders including the ASP Local Project Team (albeit changing people) and the research team - around the Adult Survivor Pilot was needed at the site.

Re-connecting with the Mid North Coast Site

The research team worked to re-engage with the local stakeholders at the site which included workers from Violence, Abuse and Neglect, Mental Health and Alcohol and other Drug Services. The aim was to work through any communication and strategic issues in the development of the service model and subsequent evaluation process. A series of re-connection strategies were put in place.

1. A MNCLHD/CLT Byron Consulting Adult Survivor Pilot Reconnect meeting.
2. A presentation from the Mental Health worker on the Kempsey based Aboriginal-led wellbeing model to develop an understanding of its development to date and core components.
3. A two-day reconnect visit to the Kempsey site.

The following section describes the key discussion points and outcomes from the ‘re-connect’ process. The following provides a clear description of moving forward at the site: how the model was to be developed, key stakeholders, the service development and evaluation, and focus on the Kempsey site.

Outcomes of the re-connect work on the Mid North Coast (Kempsey site)

There was an agreement on a way forward at the reconnect sessions between the researchers and staff across the sectors at the Kempsey site. Most significantly:

- A way forward with the pilot was decided on: drawing on the initial EOI, with the Mental Health and Alcohol and other Drug Wellbeing Model of Care being used as a foundational structure to begin work on integrating the sexual assault component into the model at the Kempsey site. Resources would be focused to the Kempsey site.

- The AH&MRC ethics application would be co-designed and developed with local Aboriginal workers across the two sites.
- The researchers developed a revised evaluation strategy to be responsive to discussions held at the sessions.
- The scene had been set to progress to Stage Three: action research.

Responding to a shifting landscape: Iterative reflection and points of review for the research team

Throughout Stage One there was movement and shifts in ASP Project staff, approaches, ways of working, approach to the model (or integrated ways of working), and geographic location for the pilot service. It was taking time to find the 'starting point' on which to start the action research. In March 2021, the ASP Local Project Team temporary project lead changed. The research team continued their communication with the Aboriginal clinicians in Kempsey who were also considered the site leads at the time. This was particularly critical as the pilot was focused on an Aboriginal-led model based in Kempsey.

In April, the research team were informed that KPMG were being contracted by the site to project manage and lead the ASP Project at the site. The research team were committed to staying engaged with the local site leads and aimed for consistent and open communication. The research team continued to work with the newly structured ASP Local Project Team (which consisted of Violence, Abuse and Neglect Service staff and KPMG) through strategic service and project development meetings. KPMG's role was to fast track the development of the service and design a *Model of Care* to respond to adult survivors. The aim was that this process (from consultation, stakeholder engagement, creating cultural safety, and engaging with the community) would be completed in eight weeks. These changes saw a shift from the original EOI – an Aboriginal-led wellbeing model based in Kempsey to a project-managed development of a *Model of Care* in Coffs Harbour. It was agreed that KPMG would develop the model of care with a limited timeframe and the research team would start the action research process to evaluate how the *Model of Care* was working in Coffs Harbour.

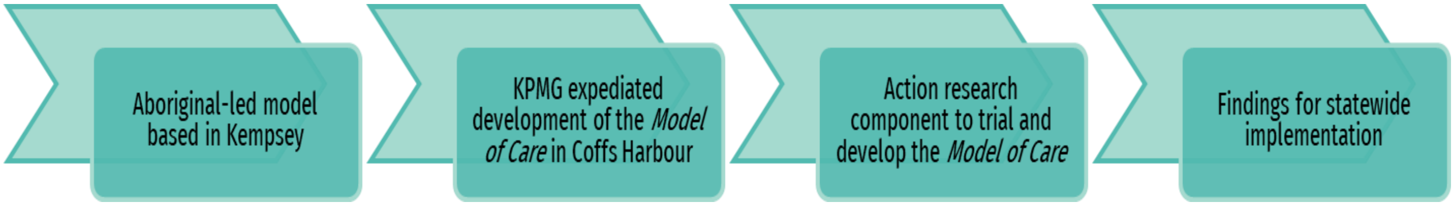

Figure 15: Changes to approach in the MNCLHD

3. Stage Two: Developing a Community of Practice

The research team worked with the ASP Local Project Team to re-visit the key stakeholder mapping exercise that began in Stage One. During the development of the *Model of Care*, the focus was on internal MNCLHD Sexual

Assault, Mental Health, Alcohol and other Drug, and Aboriginal Health staff. The inclusion in the Community of Practice of local non-government organisations and Aboriginal Community Controlled organisations were critical in order to further develop flexible, culturally safe approaches. It was particularly important to hear from local Aboriginal service providers outside of Health as their voices had been missing from the model of care development work. Other areas targeted to be included were: disability services, domestic and family violence services, legal services and adult survivors NGOs. The project lead developed a list of key stakeholders that included relevant local NGOs as well as health services.

MNCLHD Community of Practice: Participation summary

The following table outlines MNCLHD Community of Practice service representation:

MNCLHD Services	**Non-government organisations**	**Other services**
Adult Survivor Pilot Team Sexual Assault Service Aboriginal Clinical Leadership – Mental Health and Drug and Alcohol Services Aboriginal Health Program, Coffs Harbour Child Adolescent and Family Service, Hastings Macleay Refugee and Multicultural Health, Public Health Unit Intellectual Disability Health Service Zero Suicides in Care Initiative	Warrina Domestic and Family Violence Service Interrelate Mid North Coast Legal Services Galambila Survivors and Mates Support Network	NSW Police Force
Total number of services represented: 14		
Total number of participants: 23		

The following table shows participation in the CoP meetings:

Community of Practice	**Attendance (excluding research team)**
Meeting 1: August	16 participants
Meeting 2: September	16 participants
Meeting 3: October	13 participants
Meeting 4: November	10 participants
Meeting 5: December	12 participants

4. Stage Three: Further development of the integrated service using action research

The aims of developing a service at this site had evolved from the initial EOI concept. Rather than developing a service from the beginning, the aim of the iterative work for the CoP was to tweak and further enhance the *Model of Care* that was developed by Health staff and facilitated by KPMG. A new ASP Local Project Team had been established and KPMG had completed their work. The key areas of exploration in this action research stage were: highlighting cultural safety and approaches, a focus on training and capacity building, and supporting the direct client work. In addition, the following site-specific questions which had initially been co-designed with Mental Health and Alcohol and other Drug staff at the Kempsey to evaluate the planned local Aboriginal-led model were kept central to the research. Although these questions were not explored explicitly in the study at the Coffs site, it was critical that they continued to inform the developmental approach to the *Model of Care* to ensure practices that responded appropriately to Aboriginal people, families, and communities. The co-designed questions were:

- How is the service culturally safe for users of the service, staff, and communities?
- How can a health service implement a holistic and flexible approach (ways of working)?
- What is the role of community engagement and community development work in developing and sustaining the model (ways of working)?
- How do culturally valid understandings shape service provision and responses (including spirituality, kinship, family, connections)?
- How do services effectively recognise the impacts of colonisation, racism, stigma, social disadvantage, trauma and loss and respond appropriately to the impacts?
- How can strengths of individuals, families and communities be drawn on in developing service responses?
- How does an egalitarian service structure with collective decision-making work in the context of current NSW Health structures (including siloed service systems)?
- What are the training and supervision needs of staff (specialist and more broadly)?

Establishment of a Specialist Aboriginal Advisory Group

As recommended by the AH&MRC and as part of ethical practice, an Aboriginal Specialist Advisory Group was established on the MNC to oversee the ASP Project at the Coffs Harbour site. The District Aboriginal Wellbeing and Violence Prevention Coordinator played a key role in engaging local stakeholders and bringing the group together. The group would:

- Provide cultural expertise on the development of the integrated service model for adult survivors of child sexual abuse in Coffs Harbour using an action research approach,
- ensure that the service was culturally appropriate and culturally safe for the local community,
- ensure that the project was accountable to the local community, and
- ensure that local knowledge was identified and acknowledged.

It was anticipated that the Advisory Group would maintain effective mechanisms for:

- An initial meeting to discuss the development of the ASP service using an action research approach.
- meetings to provide input into the model which would be developed iteratively at a local level using a Community of Practice (CoP) made up of local clinicians and workers.

- A final meeting to confirm the model is culturally safe and appropriate for the local Aboriginal community.

The Advisory Group was made up of members from both NSW Health and Aboriginal Community Controlled organisations. The research team met with the Advisory Group 3 times over the life of the project and the group provided significant input into the action research project.

Trialing the *Model of Care* using a community of practice

CoP 1: Establishing the Community of Practice, consolidating service needs for adult survivors, and introducing the MNCLHD model of care

The key focus of the first CoP was to introduce the project, provide an overview of the action research process, explain the role of the CoP, and explore current needs, barriers and service gaps for adult survivors in the Mid North Coast. The ASP local project team provided an overview of the draft model of care, development of which began prior to the CoP formation.

The research team provided feedback collected from key stakeholders in the Mid North Coast in Stage One of the project, to provide a foundation for discussions about how to start to develop a new integrated service for adult survivors. This feedback included: changing experiences for survivors, changing experiences for service providers, and barriers and enablers of a new integrated approach.

The key discussion points in the CoP included:

- Centring survivor experiences in developing a new service.
- Key elements to creating safety in the physical environment.
- Mutual opportunities for learning from Health and NGOs.
- Intersections with police and legal systems, particularly criminal justice responses.
- Expanding scope of practice through alternatives to the medical model.
- Cultural safety and appropriateness of the service for Aboriginal communities on the Mid North Coast.

CoP 2: Training and broader capacity-building

The key focus of the second CoP was on capacity-building, training and workforce support needs. The CoP built on data from stakeholder consultation sessions and feedback from CoP participants in the previous meeting and reflections. The ASP Local Project Team presented updates around the *Model of Care* and service development including recruitment processes. The CoP provided preliminary feedback around the first draft and endorsed ongoing consultation with the CoP and priority populations.

The key discussion points around the model of care included:

- Elements to establish safety for survivors to access services.
- Expanding ideas of ‘addressing trauma’ beyond specific modes of therapy and counselling.
- Ability of service responses to positively or negatively impact survivors’ sense of self.
- Elements of flexible ways of working.
- Enablers of interagency collaboration and coordination.
- Embedding choice and flexibility in the *Model of Care* rather than a ‘one size fits all’ approach.
- Attention to language in naming the service, staff roles and describing survivors.

The research team facilitated discussions around training gaps and opportunities. Key points included:

- Systemic training gaps across the system and lack of confidence responding to child sexual abuse.
- Training gaps around working with mental health and substance use (e.g., for clinicians with primary experience in a sexual assault context).
- Recognising expertise held within local services around child sexual abuse and priority populations, particularly Aboriginal Community Controlled Health Organisations.

CoP 3: Effective skills and knowledge for working with adult survivors

The key focus for the third CoP was on developing an understanding of skills and knowledge required to work effectively with adult survivors of child sexual abuse across service sectors. The CoP built on data from CoP participants in the previous meeting and reflections. The ASP Local Project Team provided an overview of current staffing and workforce issues and the development of the physical space of the service.

The key discussion points included:

- Opportunities for mutual training and consultation to reducing siloing of skills and knowledge.
- Building capacity to work with survivors with ‘complex needs’ to reduce exclusion from services.
- Consumer participation and direct consultation with survivors.
- Focusing on relationship-based approaches rather than a singular framework or therapeutic model.
- Opportunities for training around working with priority populations (e.g., Aboriginal communities, migrant and refugee communities, people with disability).
- Identification of cross training opportunities e.g., legal service offering info session on legal rights and redress for clients of ASP.

CoP 4: Supporting service development

The key focus for the fourth CoP was on continuing to use the expertise of the group to develop the new pilot service, *Model of Care* and to discuss components of effective service provision for adult survivors. The research team presented a summary of work of the CoP so far and key themes from the previous month’s reflections. The ASP Local Project Team provided an update around their service development, partnership work, and direct client work.

The key discussion points included:

- Consultation around naming of the new service.
- Consultation around development of a safer physical space for survivors, including cultural safety considerations and approaches to engaging Aboriginal expertise.
- Challenges of appropriate recruitment and resourcing.
- Effective ‘launch’ of new services and development of referral pathways.
- Opportunities for virtual support through existing Health structures.
- Embedding a collaborative approach in the model of care with other Health services and NGOs.

CoP 5: Wrap-up of the Community of Practice and key messages for continuation of the work in MNCLHD and informing statewide implementation

The final CoP incorporated two sessions. The first session was a wrap-up of the Community of Practice led by the ASP Local Project Team and discussion of next steps. The second session was a reflective consultation group led by the research team around key messages to inform both statewide implementation and continuation of the work in the MNCLHD. A representative from the Ministry of Health also presented an overview of the plans for statewide implementation.

The key discussion points from the wrap-up discussion were:

- Continuing to develop the *Model of Care* through an iterative approach.
- Continuing Aboriginal community consultation as established in the project.
- Direct client work and examples of flexible, holistic support provided to survivors.
- Shifting expectations and norms around ‘mainstream’ ways of working.
- Discussed continuation of the Community of Practice after the research project, with facilitation from the ASP local project team.

The key discussion points from the group were:

- Key workforce capabilities for working with adult survivors.
- Supporting integration between Health and NGOs.
- Considerations for regional and rural implementation.
- Learnings around cultural safety and engaging with Aboriginal communities.
- Enablers of effective partnerships and collaboration.
- Authorising environments and structures.
- Sustaining system-wide changes to improve survivor experiences.

At the conclusion of the final CoP, the group discussed a plan to continue meeting as a Community of Practice within MNCLHD led by the ASP Local Project Team and existing CoP members.

Engaging with the Specialist Aboriginal Advisory Group

The research team were invited by the Chair of the Specialist Aboriginal Advisory Group to attend three meetings over the life of the research project. The researchers provided the Specialist Aboriginal Advisory Group with an update on the action research and sought guidance around the research questions, data collection practices and approaches to ensure that they were culturally safe, appropriate and meaningful.

The Specialist Aboriginal Advisory Group also provided advice and feedback on the *Model of Care* which was iteratively incorporated by the ASP Local Project Team. Members of the Specialist Aboriginal Advisory Group contributed to the broader learnings for state-wide implementation by providing input on minimum components of a service for survivors that is safe and effective for Aboriginal people as well as supports required for Aboriginal staff. The feedback collected at these meetings was fed into the broader data set and is described in the findings section of this report.

Outcomes for Site 2

A *Model of Care*

As part of the Adult Survivor Pilot project, the MNCLHD developed a model of care for guiding service provision for adult survivors. This model is still being refined.

The vision of the model is:

*This model of care for the Adult Survivors of Child Sexual Abuse Service outlines the framework to provide a culturally safe, trauma-informed, therapeutic response to the survivors impacted by the effects of long-term impacts of CSA. This includes supporting people after first disclosure, therapeutic counselling, assisting with accessing services, and support with navigating the judicial system if that is a chosen pathway (*MNCLHD Adult Survivors of Child Sexual Abuse Service Draft Model of Care document).

There are four primary functions for the Service, which are outlined below:

Figure 16: The primary functions of the MNCLHD service (provided by MNCLHD)

The model of care outlines the points of difference from a mainstream health service, as;

- the length of care is dependent on the client, the complexity of their health needs and the goals they set,
- there will be an integration of mental health, alcohol and other drug and sexual assault counsellors,
- the service is located in a community-based setting,
- the service provides greater capacity for flexibility and time for client advocacy, including court preparation and court support, and
- the service privileges a culturally safe model for increased accessibility of Aboriginal people and communities.

The focus of the model was also on capacity building. In the first half of 2022 CoP and Aboriginal Specialist Advisory Group members and associated organisations attended training run by Survivor and Mates Support Network (SAMSN) in responding to disclosures of sexual abuse across the district. Capacity was also built through those agencies with who provided clinical intervention to have access to Blue Knott Foundation training in working with complex trauma.

The overall and consistent lens of the Coffs Harbour Pilot was to ensure a culturally safe model. Aboriginal cultural considerations to support the Aboriginal workforce and to increase accessibility of the Service was central to the model implementation supported by the Aboriginal Specialist Advisory Group.

Although there were workforce issues resulting in limited staffing to trial the model of care through the action research process, the ASP local project team continue to work on trialing and developing the *Model of Care* through engaging and working with clients and working and consulting with Community of Practice and Aboriginal Specialist Advisory Group partners. Due to the limited ‘action’ between the ‘research’ cycles in the research project, this report can only provide initial findings from limited data obtained from the site about the effectiveness of the model.

Section Six: Research findings

The data sets were analysed using NVIVO to determine key themes and findings across both research sites. The findings are described below and include:

- Conceptualising the Pilot: how the action research drove service development.
- Conceptualising and responding to adult survivors of childhood sexual abuse: Core practice principles.
- Responding to complexity in service provision: what does an effective service for adult survivors look like?
- Learnings for developing a safe service for Aboriginal people, families, communities and staff.
- Re-defining integration: how can services work collaboratively at the intersections?
- Capacity building and training to strengthen broader sector responses.
- A skilled and trained workforce.
- Sustaining system-wide change.

1. Conceptualising the Pilot: the key components of action research that drove service development

The importance of a ground-up approach to respond directly to local need: exploring contextual factors

The advantage of working alongside two separate and distinct LHDs allowed for grounding the service development in a local approach harnessing local expertise. The two sites were very different in their context, geographical reach, workforce capacity, and breadth of external key stakeholders such as NGOs and community organisations, and resources. Exploring what did and did not work in each area contributed to the broad data set that was used to find key themes across the two sites while still valuing the local context. It is critical to acknowledge that a model generated in one local area cannot be directly transferrable to another.

For example, in Site 2, key considerations for rural and regional implementation were explored. Additional considerations for LHDs based in these geographic locations include:

- Transport for clients and staff as a significant barrier.
- Recruitment challenges and qualification gaps, and challenges in balancing a skilled workforce with a need to recruit to positions from a smaller pool.
- Confidentiality and navigating conflict of interest for survivors accessing services within smaller communities.
- Safety for Health workers and other professionals living locally who are survivors and need to access support services.
- Limited community resources.
- The urgency of developing and building a First Nations workforce.

> There is a real struggle to actually find people with qualifications suitable to sit in these roles, so they sit open for extended periods of time.
>
> NGO CoP Participant,
> Focus Group, Site 2

> *We are a very, very innovative community in this region. Often at different times in the funding cycles, we haven't been funded well. That's taught the [local area] about working together and we come up with solutions to address gaps…. We have good relationships* (NGO Participant, Community of Practice, Site 2).

The role of project champions

Through the scoping work undertaken in Stage One of the research, it became clear there was an identified 'nervousness' from Health staff about working in an iterative way in a pilot. To alleviate these concerns, local project leadership or 'champions' were critical to drive the process. A lead who oversaw the operational aspects of the project, made the connections between the ASP Local Project Team and the researchers, and navigated the complex service system was critical. Project champions were important to:

- drive the work and maintain stamina,
- support skill development of ASP Local Project Team members,
- strategise about new approaches,
- advocate for the ASP project (particularly across the service sectors and up through the Health system and local LHDs),
- support staff, and
- ensure that an iterative, ground up project could be delivered in a complex system and range of service settings.

> Supporting team members to work outside their comfort zone is important and this has taken a multifaceted approach from the Clinical Coordinator, the Project Manager, the Research Team and Senior Manager.
>
> ASP Local Project Team Member, Individual Reflections, Site 1

At Site 1, the early recruitment of a dedicated Project Manager and Clinical Coordinator ensured the development of a clear internal governance structure from which all additional recruitment activities were established and partnerships developed. Both the project and clinical lead brought extensive trauma-informed practical experience as well as management and leadership skills to the roles that allowed for a co-leadership approach to the project.

At Site 2, the District Aboriginal Wellbeing and Violence Prevention Coordinator took a leadership role by championing Aboriginal Governance by coordinating and sustaining the local Aboriginal Specialist Advisory Group who provided ongoing feedback to the ASP Project.

An authorising environment as key to project success: key governance structures and supportive management

Executive endorsement and support were essential for the practitioner-led work to occur. The data highlighted that Executive leadership which embraced the action research process and supported the ASP Local Project Teams to trial new ways of working within the Health system was critical for new collaborative practices to develop. This leadership also ensured that the team were supported to move through the uncertainty and fluid stages of developing a new service. Executive support was important both *within* the VAN sector, as well as *across the service sectors*. This type of dual elements of leadership was demonstrated at Site 1 where there was both a strong governance structure within the VAN sector supporting the ASP Project (see figure below), as well as a cross sector Advisory Group to oversee the work and develop partnerships across the VAN, Mental Health, Alcohol and other Drug Sectors as well as broader Health and NGOs.

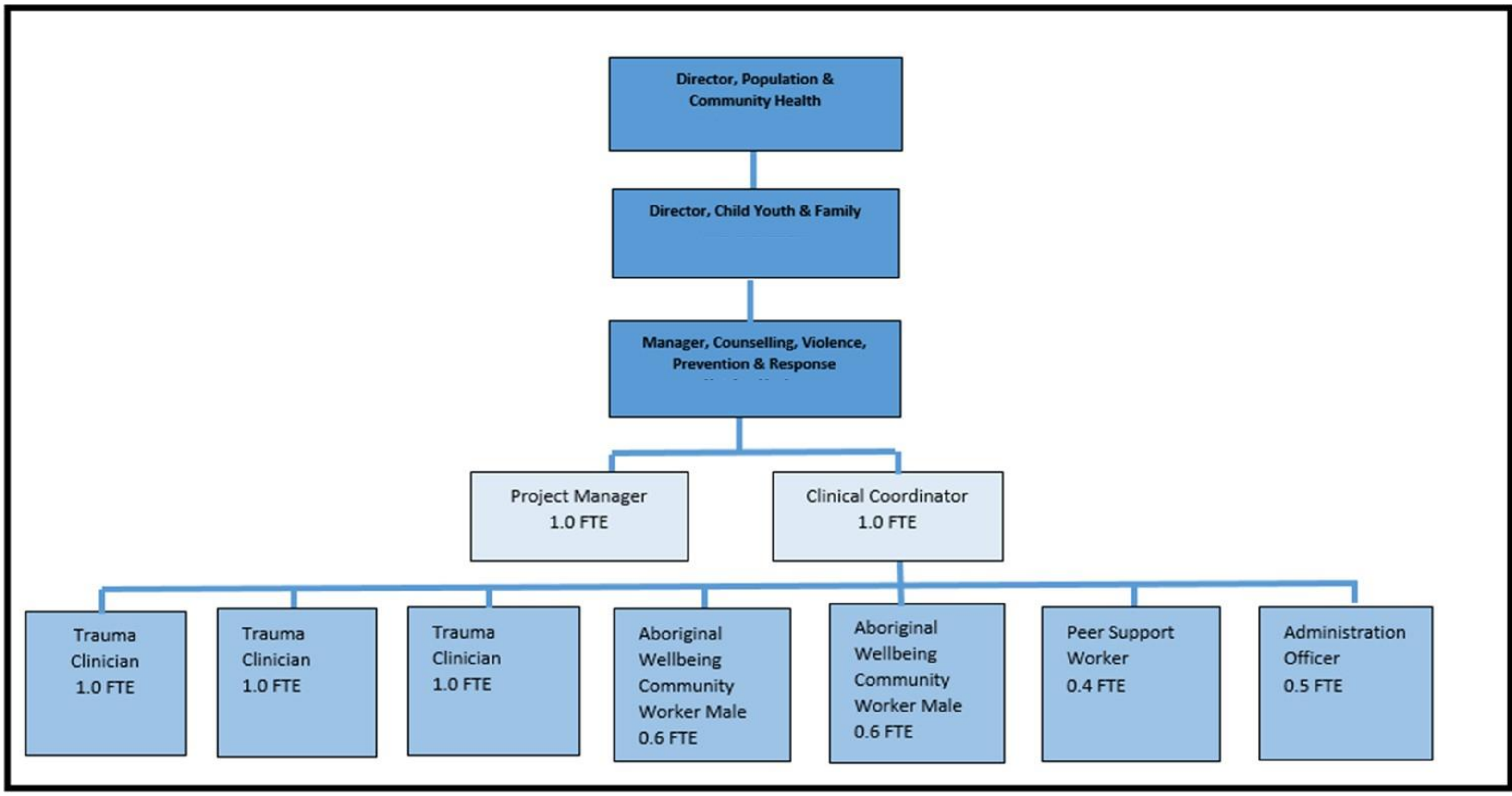

Figure 17: The SESLHD ASP Local Project Team's governance structure

Site 1 Practice example: The SESLHD Adult Survivors Pilot Project Advisory Committee

SESLHD established an Advisory Committee to support the development of the ASP project. Section 4 of this report provides a list of members. The Advisory Committee was responsible for:

- Embedding the action research, co-design approach for SESLHD.
- Ensuring involvement of key partners.
- Contextualising capacity building activities within SESLHD and partner NGOs.
- Providing advice on pathways between the SESLHD Pilot Project and other relevant services.
- Providing advice on strategic planning, models of care, and related activities.
- Providing advice and support to improve skills and confidence of health professionals and increasing adult survivor access to mainstream health services.
- Providing advice and access to relevant hospital, population or community-based initiatives or programs.
- Review the ongoing evaluation process of the project to consider the impact of these initiatives across the LHD.

Guidance of the SESLHD Advisory Committee was crucial when issues were raised around direct practice with survivors and working with mental health and alcohol and other drug use outside of a medical governance model. The ASP Local Project Team identified a need to support clinicians to build confidence working with risk and complexity, for example with suicidality or high-risk alcohol and other drug use, without direct medical governance. The Advisory Committee provided feedback to the ASP Local Project Team supporting them to explore new ways of working and identified relevant existing policies and procedures. Support was also provided around strengthening integration with other Health services as an alternative to direct medical governance, ensuring survivors would have access to appropriate pathways depending on their needs.

Site 2 Practice example: Championing Aboriginal leadership and governance

As described in Section 5 of this report, the Aboriginal Specialist Advisory Group was established to provide cultural expertise on both the research and service development streams of the ASP Project on the Mid North Coast. The aim of the group was to provide advice and feedback to guide the development of the new service so that it was: culturally appropriate and culturally safe for the local community, that the project was accountable to the local community, and that local knowledge was identified and acknowledged. The partnership approach of the group that included Aboriginal workers from both Health and ACCHOs was a key step to begin the collaborative work within the local area. The Aboriginal Specialist Advisory Group engaged in discussion of what and why cultural safety is important for the local community. They also explored the cultural and safety needs for Aboriginal staff working in and alongside the project to build skills and reduce vicarious trauma.

Researcher insider/outsider roles and the importance of relationships in a participatory approach

Developing a trusting and transparent relationship between the research team, the ASP Local Project Teams and local key stakeholders was critical foundational work of the project. In addition to formal weekly project meetings and key stakeholder meetings, the research team had ongoing informal contact with the ASP Local Project Teams to support the service development and provide guidance and additional support to manage unexpected challenges or issues that arose. Feedback from the two sites indicated that support from the research team was key to center the iterative way of working (reflection/feedback/planning) as well as consultation with a body outside of the Health system about the project. This aligns with current literature that explores and highlights the importance of the role of researchers as being both ‘inside’ and ‘outside’ players at action research sites.

> Feedback and direction from CLT Byron Consulting was really helpful and validating. A few things came up… and it has been really helpful having some neutral feedback and suggestions.
>
> ASP Local Project Team Member, Individual Reflections, Site 2

Sitting with uncertainty

Part of the process of using an iterative approach to develop a new service required the ASP Local Project Teams to sit and work with levels of uncertainty. Working in this way within a highly structured Health system was challenging.

Some of the challenges that were identified through the data included:

- Starting a service ‘from scratch’. Evidence explored in the literature review[11] highlighted that an already established integrated service response to adult survivors of childhood sexual abuse across the three sectors: Sexual Assault, Mental Health and Alcohol and other Drug Services did not exist. The sites were required to start the process of service development from inception.
- Trying new approaches and practices and building new procedures within a structured Health system that may not have the flexibility of NGOs. For example: trialing more flexible services responses such as online appointments with clients or appointments outside the Health building.
- The impact of a pandemic on the broader Health system and staff. There was ongoing uncertainty about the longer-term effects.
- Engaging with survivor expertise was crucial throughout and seeing survivors as ‘partners’ in the project. This involved deconstructing traditional health understandings of consumer participation and challenging traditional client/service relationships.

Any work without clear directed policies and procedures can be seen as dangerous/risky within the Health Setting.

ASP Local Project Team Member, Individual Reflections, Site 1

The critical piece: strong engagement with a Community of Practice to create opportunities for partnerships and collaborative work.

> *Having this community of practice has been absolutely incredibly valuable for us in feeling validated… making sense of a client-informed, trauma-informed pathway, was being reinforced by those already in the field doing this work in incredible ways. Often trauma service delivery can feel really isolating. There is just not enough of us and you are forever looking for your people, and this has been really affirming saying here these are our people. It gives us the confidence to keep going.*
> (ASP Local Project Team Member, Community of Practice, Site 1).

The key functions of the Community of Practice (CoP) were to: provide an environment to harness local expertise from across the service sectors; build partnerships; get ‘buy in’ for the new service from other workers and agencies working with adult survivors; and to establish broader community ownership of the process of developing the service. It was a critical element in fostering collaboration and integration. The development of the group allowed for ongoing co-design of the research data collection methods, agendas for the content to be discussed, group membership; and areas of practice to develop through the action research cycles.

Data collected highlighted the positive impact of the CoPs with participants at both sites providing feedback about the intent, facilitation, representation and work of the group. This included:

It was good that the members were supportive of the ideas suggested by the project team… It was a really hopeful start and from this first meeting there was a commitment to start some new partnerships.

ASP Local Project Team Member, Participant Reflections, Site 1

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[11] Toivonen (2019, Forthcoming)

- The importance of having the breadth of experience of workers and the type of diverse services represented, with participants wanting to promote the pilot and partnership opportunities within their services.
- The benefits of having space to think and reflect on the complexity of work with adult survivors.
- The priority being given to exploring new ways of working to better respond to adult survivors.
- The nature and content of each CoP led to increased understanding of other services and sectors, highlighting both strengths and limitations of each sector's approach to working with adult survivors.
- Sharing of resources and knowledge.
- Interest in actively supporting the development of the pilot and specific projects evolving from the pilot.
- Participants leaving the Community of Practice feeling 'hopeful' and 'excited' around shared goals, and improvements in their skills and knowledge around working with survivors.

> I walked away yesterday and it struck me… it finally sunk in what you are doing and it is an absolutely phenomenal project! I love everything about it, particularly the design and action research wrapped up around a community of practice… I am in awe!
>
> NGO CoP Participant, Community of Practice, Site 2

I love all the rich conversation we are having because it is really forming this new service that we're developing, so thank you (ASP Local Project Team Member, Community of Practice, Site 2).

Key learning: The Community of Practice as a site of collaboration.

CoP participants at both sites provided feedback about the benefits of the CoP for a) establishing a new service for adult survivors and b) as a means to support broader integration in their local areas. Both sites recommended exploring use of a CoP or similar to develop services in other geographic areas as part of the broader rollout. Key elements of the CoP's effectiveness were identified as:

- a ground-up approach,
- a focus on action,
- mutual capacity-building and knowledge-sharing, and
- representation from a broad range of Health services and NGOs, and representation from specialist services working with priority populations.

One of the key reasons we have been successful is the work we have done in partnership. We would never have succeeded without the collective group (ASP Local Project Team Member, Reflective Consultation Group, Site 1).

2. Conceptualising and responding to adult survivors of childhood sexual abuse: core practice principles

> Getting the survivor's story out is critically important.
>
> ASP Research Project, Survivor Advocate Feedback.

Positioning the voices and expertise of adult survivors at the centre of service development

Positioning the voices and expertise of survivors at the centre of service design and development processes is aligned with evidence based, service user co-design practices.[12] This approach often requires flexibility and creative solutions to issues that arise and is likely to produce meaningful, collaborative outcomes. It is important to start from a place that positions a survivor's lived experience as a central point to all elements of the work. All decision making, planning, design and consultation should start with a survivor's own experiences, understandings of the service system and their communities, and their ideas for change. Survivors' experiences and views are not homogenous and this needs to be considered. Data from the research supported the practice of positioning the survivor's lived experience and expertise as a foundational starting point. It ensured that the service being developed responded to local need and experiences.

> "Nothing about us without us!" Survivor voice has to be central in every aspect of planning and delivery... Commitment to shared power as restorative to rebalancing power away from dependence towards empowering the survivor
>
> NGO CoP Participant, Participant Reflections, Site 1

By keeping the voice of survivors central, this approach:

- acknowledged the unique role that survivors have in developing policy and services responses,
- highlighted and valued the strengths and contributions of survivors,
- allowed the project to gain the experiential knowledge about identified gaps and problems with current service delivery,
- allowed for challenges to misconceptions and stereotypes about survivors so that the health system can better respond,
- embraced the challenge to systemic norms, addressing issues of power such as institutionalised racism, homophobia and transphobia,
- respected survivors whilst they were validated and their experience used to transform current systems, and
- supported genuine meaningful participation from survivors.

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[12] Toivonen (2019, Unpublished).

Practice Example Site 1: Development of the SESLHD Consumer Participation Strategy

The SESLHD ASP Local Project Team was committed to consumer participation as a core component driving the development of the new service. By developing a consumer participation strategy, they were able to partner up the knowledge and expertise of those with lived experience and that of the ASP Local Project Team staff. The team engaged in a process of co-design, with adult survivors who lived in the SES geographic catchment and had experience interacting with NSW Health services. Those with lived experience were respected as equal partners who were sharing expertise in the design of the service. The report outlining the process is available from SESLHD and examples of how the survivor's expertise were used in the development of the service are used throughout this report.

> They all expressed a willingness to share their experiences with the goal of helping other survivors to save years. They've all talked about that, that they've lost years, and if they had access to a service similar to the one they are building, that is informed by survivors, they would have saved time and they wouldn't avoided misdiagnosis and falling through service gaps.
>
> ASP Local Project Team Member,
> Presentation, Community of Practice, Site 1

Impact of Consumer Participation to the Project*
The opportunity to engage with consumer participants with lived experience has been an essential aspect of the project. The information shared by participants has directed and supported service delivery and the ongoing planning and strategic development of the project. The activities of survivor advocate inclusion in the project had the following impact:

1. Confirmation that the issues facing adult survivors of child sexual abuse are consistent with research currently available and the developing outcomes of the SESLHD Adult Survivor Project.
2. Widespread support and interest in the inclusion of survivor advocates in the project, by internal and external stakeholders.
3. A strong working relationship with adult survivors and the ASP Local project Team.
4. Inclusion of the adult survivor voice in all facets of the project, including clinical, environmental, and administrative services.
5. Recognition and validation of the improvement to clinical practice achieved through consultation with people with lived experience.
6. Development of consumer participation policy to inform the inclusion of adult survivors in the project and with wider Violence, Abuse, and Neglect services in SESLHD.
7. Survivor advocates who have engaged with the project have reported that the process of engagement, sharing their experience, and offering their view on what helps when supporting survivors, has been both therapeutic and validating.

***Authored by the SESLHD ASP Local Project Team.**

> Through accessing services, whether Alcohol and other Drug or Mental Health – they are only at service level – they try to tick their boxes so they pigeon hole you, label you and give a diagnosis. They provide services to treat the pockets of things but the underlying issues are never dealt with.
>
> ASP Research Project, Survivor Advocate Feedback.

Keeping the impacts of the child sexual abuse at the centre of the work can lead to adult survivors receiving a more holistic health response. This is in direct contrast to common responses that diagnose and treat presenting symptoms in silos in Mental Health, Alcohol and other Drug, and broader Health services. By holding the impacts of the childhood sexual assault and the trauma impacts at the core of the response, services will have a ***central point of connection and understanding*** of the needs of their (often mutual) clients. Findings from the analysed data highlight that by keeping this focus:

- Survivors will be spared from 'cycling' through the Health system for years (e.g. repeat Emergency Department presentations, repeat mental health-related admissions), reducing ongoing re-traumatisation and distress. This aligns with a trauma-informed approach to delivering healthcare.
- Inappropriate or shifting mental health diagnosis can be avoided as the impact of trauma is accurately recognized and responded to.
- Unhelpful or punitive responses to adult survivors can be reduced.
- Collaborative approaches across the sectors with a shared language can be developed– with each service sector working in partnership with the survivor on the trauma impacts.
- Ongoing gaps and challenges across the service sectors can be reduced so a survivor receives a more seamless service response.

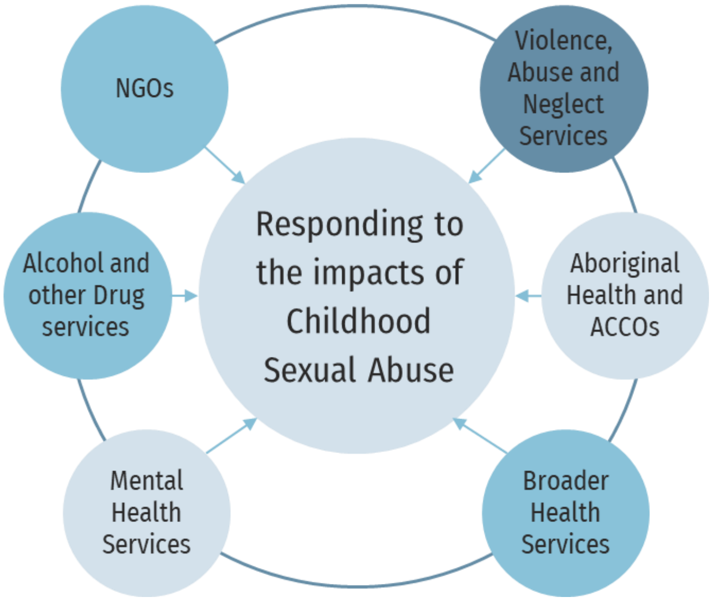
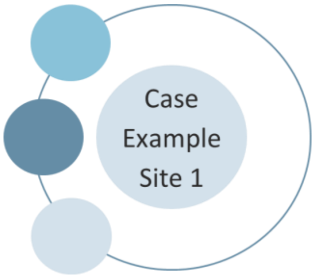


Figure 18: Keeping the CSA at the centre of the approach.

Considerations for practice include:

- Responding to trauma impacts, not just identifying and documenting ‘history of CSA’ or ‘history of trauma’. Workers must continue to make the connections and links with current health concerns.
- Addressing the trauma impacts by not letting them fade into the background when survivors experience complex mental health issues or issues with alcohol and other drug use which present as the crisis.
- Understanding issues that intersect with an adult survivor’s health – sexual abuse, intergenerational trauma, substance use, parenting, child protection concerns and family dynamics.
- Shifting from a clinical diagnosis and treatment plan to a ‘trauma-focused conceptualisation’ or a ‘holistic social, emotional and cultural wellbeing’ response to past childhood sexual abuse.



An adult survivor had been a long-term client of a range of Mental Health services for over 17 years. On reviewing her health record, it was noted she received at least 11 different mental health diagnoses and labels including Bipolar Affective Disorder, Depression, Borderline Personality Disorder, ‘Cluster B Personality Vulnerabilities’, Substance Use Disorder, Brief Episode Psychosis, Acute Psychosis, Hysterical Psychosis, Post-Traumatic Stress Disorder, Schizoaffective disorder and Schizophrenia. Following each diagnosis was a comment of ‘on the background of trauma’ or ‘History of CSA’. The CoP discussed how the multiple changing diagnoses reflected that no mental health label captured what she was experiencing and likely increased fragmentation in service responses and the survivor’s self-identity. An alternate framework was described as ‘bringing the abuse into the foreground’ and describing her experiences as the complex impacts of child sexual abuse. This could radically shift service responses and how the survivor understood herself (Community of Practice Case Study, Site 1).

The importance of developing a shared language

One of the key challenges for workers attempting to work across the intersections was the siloed and complicated language used within different areas of Health which have traditionally emerged from the medical model. For survivors, ‘clinical’ language acted as a barrier to accessing services. Developing a new shared language was an approach identified at both sites as a key enabler for development of partnerships and collaborative work.

Initial practice approaches can include:

- Moving away from medical model-based terminology of symptoms, diagnosis and treatment to ‘responses to trauma’.
- Learning from First Nation’s organisations how to shift language to include social, emotional and cultural wellbeing.
- Working flexibly to accommodate a survivor’s preferences and expertise about appropriate language for themselves, their communities and services.
- Exploring new titles for clinicians and developing alternative ways of introducing workers to survivors.
- Seeing workers as ‘advocates’ in recognition of abuse as a rights violation.

> …trying to move away from that medicalised trauma model and look at social and emotional wellbeing. Our clients seem to be responding a lot better when we talk about it in a wellbeing type of way
>
> Aboriginal Community Controlled Organisation Participant, Community of Practice, Site 2

Understanding trauma and complexity

The analysed data highlighted the importance of understanding and responding to trauma and complexity. Holding a trauma-informed lens, using a trauma-informed approach, responding with trauma-informed care and having skills to offer trauma-specific therapy were all identified as critical components for a new service, as was understanding intergenerational trauma and how that impacts social, cultural, and emotional wellbeing. It was useful for the sites to draw on the Trauma-Informed Care (TIC) model[13] – using a strengths-based framework, which recognises the complex nature and effects of trauma and promotes resilience and healing. The key principles of TIC which need to be considered are:

- Safety- creating areas that promote a sense of safety.
- Trust - providing clear and consistent information.
- Choice - providing options for treatment and care.
- Collaboration - maximising collaboration between health care staff, patients and their families.
- Empowerment -building upon a patient’s strengths and experiences.
- Culture- providing culturally safe responses.
- Identity - how a survivor identifies should inform how the agency staff work with them.

Using a trauma-informed lens as a foundation will provide the platform for how workers can begin to work with adult survivors. The ASP Research Project Survivor Advocates designed the following graphic to strengthen and guide the direct client work.

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[13] NSW Ministry of Health (2019a).

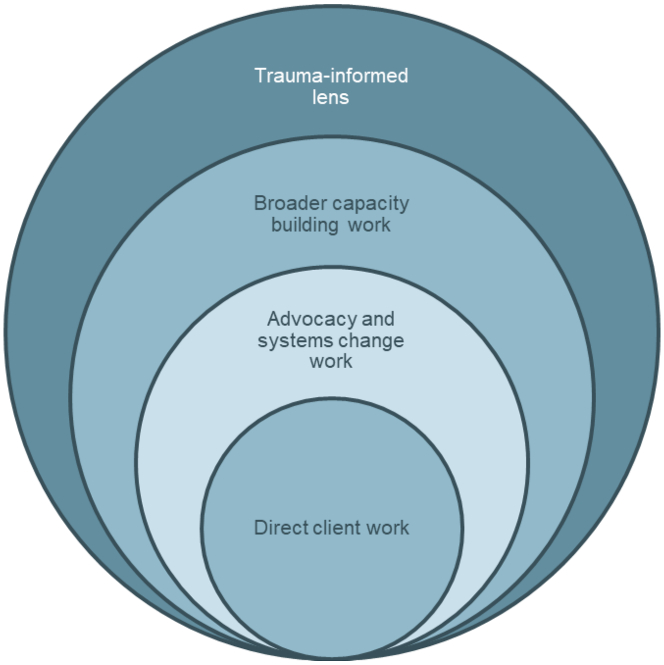


Figure 19: Using a trauma-informed lens for practice

Critical thinking about power and systems

> Central to the work… has been a commitment to shared power. As we know working in this space, adult survivors of child sexual abuse have experienced an abuse of power and control, often resulting in feelings of powerlessness, shame and silence. When embarking on a participatory design process, the project team made a commitment to share power, to acknowledge voices of those who are rarely heard and to recognise that at the centre of our work.
>
> ASP Local Project Team Member, Community of Practice Presentation, Site 1

Many of the places where adult survivors seek support are steeped in power, with particularly problematic systems such as the criminal justice system, child protection system, and involuntary Health services. Engagement with these systems can often leave adult survivors in a position of powerlessness, resulting in stigma, shame, and silence. For adult survivors who have experienced Institutional abuse, the system's responses can cause secondary victimisation. This can also leave survivors of violence highly attuned to power dynamics in relationships, including those with service providers. This highlights the importance of building trust and relationship-focused work.

Traditional client-professional relationships within Health systems, position the medical professional as the expert whose medical knowledge gives them power in the relationship. The adult survivor's lived experience, which makes them an expert in their own life, has not always been acknowledged and they can be positioned as a passive recipient of services. The process of deconstructing power and its dynamics is critical in the development of an integrated service that has survivors as central and involves them in a meaningful collaborative partnership with Health.

Ways in which an understanding of power can be brought to survivor-led service development are for workers to:

- Acknowledge and respond to the power structures within the Health system, and acknowledge the Health system as a possible cause of harm and trauma for many survivors.
- Work to implement systems change to reduce further harm and trauma in future responses.
- Acknowledge, honour and utilise the expertise of survivor's lived experiences across all parts of service design.
- Action a commitment to sharing power and reciprocity in the relationship between workers and survivors.
- Understand the intersections of power and language in communication and documentation.

> ...particularly for Health, is acknowledging the power structures within the system and that for some survivors they may have experienced being traumatised by the health system... They carry that and bring that with them. The system could have been traumatising or retraumatising. So being transparent around that, acknowledging those experiences, and not shying away or denying or minimising would be really important to address.
>
> NGO Participant, Community of Practice, Site 1

Additional ways power could be shared with regards to priority populations included:

- understanding and keeping central in any approach, self-determination for Aboriginal and First Nations people,
- understanding rights-based approaches for people with a disability, and
- adopting inclusive practices for the LGBTIQ community.

It is also important to remember that health services may feel unsafe culturally. There may be components of micro and macro racism that makes it difficult for survivors to trust and engage with workers. Key is acknowledging the role health workers have played in past and historic trauma and having discussions with clients about how they can work safely with them.

3. Responding to complexity in service provision: what does an effective service for adult survivors look like?

Moving from a 'service centered' to 'client centered' approach

> What would it look like if we provided a service where the client was truly at the centre of our practice?
>
> ASP Local Project Team Member, Individual Reflections, Site 1.

Traditionally, Health services have specific intake and eligibility criteria included in policies and procedures, practice approaches and responses to clients, based on the service provision. The data from this research found that services have tended to 'stay in their own lane' using their tailored expertise working with a client on one presenting issue, such as a mental health issue, alcohol and drug use, or a crisis response to a sexual assault. This meant that exploring the complex and multiple issues a client may be grappling with at any presentation, is either non-existent or minimal. Limited resourcing further exacerbates this issue, for example, with waitlists and a need to move the client on quickly from a service. The outcome for adult survivors with multiple and complex issues has often been exclusion from services.

> **They provide services to treat the pockets of things, but the underlying issues are never dealt with. Little band aids that don't help.**
>
> ASP Research Project, Survivor Advocate Feedback.

> Long and flexible engagement process by pro-active clinicians is important. Giving up on clients or applying hard criteria because they don't show up is not going to work when a client is experiencing chaos or is in survival mode. Meet the client where they are at on their journey and to be adaptable to clients' needs as workers are important attitudes and practices in this work.
>
> Health Child Protection Community of Practice Participant, Individual Reflections, Site 1

The CoPs and ASP Local Project Teams at both sites explored practices and responses that privileged the needs of the client rather than the service. NGOs have traditionally worked in this way and some areas of Health have moved into this space, with precedents such as the SESLHD Assertive Drug and Alcohol Service. Drawing on these approaches, the two pilot sites aimed to use a 'flip it on its head' approach, moving away from what the service needs and expects to what the client needs and expects.

Rather than them trying to fit with our service, we try to fit with them (Drug and Alcohol Service Participant, Community of Practice, Site 1).

The following key criteria emerged as findings that can be used to guide a client-centered and led approach:

- The service is centered around survivor needs, whatever they look like, with the flexibility to respond to, and accommodate different needs and changes over time.
- Staff are prepared to move and change their practice focus accordingly. This might mean a move from advocacy to providing practical support, to engaging in counselling or therapy, or supporting social and emotional wellbeing throughout the journey with the client.
- Considerations of power and re-defining the client/worker relationship as a partnership is key, so that power is distributed to the client and not held by the service.
- There is an understanding that client-driven support won't always align with the plans and timelines services expect and this needs to be responded appropriately to by staff.
- The therapeutic alliance takes time and flexibility from the perspective of the service.
- The service focus is on building safety with the client.
- The importance of broadening definitions of what makes an interaction 'therapeutic' to consider how the power of validating conversations, practical support, and communicating belief in a survivor's story is core to client-centered responses.
- There must be an acknowledgement of past harmful health responses that may impact on how a survivor engages with services.

> A virtual wrap around response with the client at the absolute centre of our purpose... this project is shifting the way we do business and will give us better outcomes for our clients.
>
> ASP Local Project Team Member, Community of Practice, Site 1

Traditional 'service centred' approaches

- Rigid eligibility criteria.
- Therapeutic approaches and modalities developed by the service and imposed on clients.
- Short time limited interventions.
- Engagement with clients is rigid, office based, and safe for the service.
- One type of service is fit for all clients.

A move to 'client centred' approaches

- Broader eligibility criteria.
- Practice responses discussed with clients according to their current need.
- Appropriate time expectations of engagement with the client.
- Engagement with clients is flexible, outreach and safe for both the clients and staff.
- The service engages with individual clients to meet their specific needs. They are mindful of the needs of Aboriginal people, families and communities and for those from priority population cohorts.
- Using relationship-based rather than individualised therapeutic strategies.

Figure 20: A move from service centred to client centred approaches.

How do we make workers who are academic based treat us with empathy?

ASP Research Project, Survivor Advocate Feedback.

> The importance of relationship and engagement. Often we can be focusing on a certain model or way of being and forget the most important thing is engaging, building relationship and that sometimes its measured in fairy steps not leaps and bounds. But it's just sitting and spending time and being able to listen, being with that person and their pain, and being there for them, often it's the really simple things that are the most important.
>
> Sexual Assault Service Participant, Community of Practice, Site 2

The importance of building a trusting, reciprocal relationship is a key feature of a collaborative partnership between the worker and the survivor. For survivors who are hyper-intuitive and hyper aware of neglect and rejection because of histories of harmful betrayals, this is a key consideration. To create an empathic connection with a survivor is a first step to develop meaningful engagement with them. Key to this approach is developing safety for the survivor.

We can't do it without the client having safety and connection…that sliding doors moment, she needed the wrap around service she is getting now, but she also needed that as a child. The level of trauma she experienced, and at no point that any safety was ever offered to her (Child Protection Participant, Community of Practice, Site 1).

The ASP Research Project Survivor Advocates developed the following diagram to support the development of the partnership work and to remind workers *How am I working with this client? What do they need, and what do I need?* The circles highlight the key components for workers to consider to start to build safe relationships with their clients.

Figure 21: Key elements to a partnership approach with a client

Case
Example
Site 2

Case Example Site 2: Developing a relationship based on trust

The survivor expressed ambivalence and anxiety around attending an Adult Survivors of Child Sexual Abuse Pilot Service (ASP). The ASP worker normalised and validated these feelings. The worker explained that the survivor may feel anxious attending appointments and normalised the feeling of ‘wanting to cancel’. The worker reiterated that the service was voluntary and the survivor was in control of engagement. The survivor expressed frustration and disappointment in previous therapeutic relationships. The worker gave the survivor explicit permission to reject anything they said that didn’t feel right and invited the survivor to tell the worker if she has a strong reaction to anything suggested.

Re-defining client ‘readiness’

There was widespread acknowledgement that ‘trauma services’ often expect survivors to demonstrate and express readiness to ‘receive’ support and achieve a level of ‘stability’ in their life before being able to work with a service. The pilot sites explored alternative approaches involving ‘meeting the survivor where they are’ in their life and providing a responsive service. This involved:

- Engaging with clients beyond their ‘symptoms of abuse’.
- Not expecting a change in a survivor’s alcohol or other drug use or mental health symptoms prior to or during engagement.
- Not putting the onus on survivors to change circumstances beyond their control (for example, being homeless or experiencing domestic violence from their current partner).
- Incorporating a focus on ‘meeting the client where they are at’.
- Lowering thresholds for access to the service – including developing broader eligibility criteria that invites clients in rather than ‘keeping them out’.
- Taking a non-punitive approach – for example working flexibly with clients who use alcohol and other drugs (i.e., not refusing service if a person has recently used drugs and alcohol) or responding to changing mental health issues (for example: working with a client in an inpatient unit rather than denying service because they are ‘too unwell’ or allowing them to change or miss appointments according to need).
- Ensuring that there are appropriate responses for clients from culturally and linguistically diverse and refugee backgrounds, with an understanding of trauma impacts from past experiences of disenfranchisement, war, and loss and

> What we discovered though, is that when we apply a client journey to that model it doesn’t fit. The client journey is very different to what the system provides or the system’s expectations.
>
> ASP Local Project Team, Community of Practice, Site 1

> We spoke about client’s ‘readiness’ to engage in supportive counselling work. I feel best practice would be that this service was able to respond supportively to a client at any point of ‘readiness’… And to be able to accommodate the natural ‘back and forth’ of engagement along any point on that continuum.
>
> Child Protection Participant Community of Practice, Reflections, Site 2

grief, as well as culturally appropriate engagement and use of interpreters.

- Providing a service that is welcoming of all genders and sexualities. This includes providing the option for the client to work with someone from the LGBTIQ+ community or connect them with a LGBTIQ+ worker external to the service.

The critical importance of flexibility and responsiveness (pro-active engagement)

> We need to build a truly trauma informed perspective where client safety, building trust and the need for flexibility and choice is often counter to standard health policies.
>
> ASP Local Project Team,
> Practitioner Reflection, Site 1

Flexibility and responsiveness are key to working with an adult survivor who may be experiencing the multiple impacts of trauma at any one time. For Aboriginal people, families and communities, this includes the cumulative effects of colonisation and ongoing racism, and effects of intergenerational trauma. Examples of punitive and inappropriate responses that lacked flexibility and responsiveness were explored in all stages of the research and were captured in the data set. The ASP Local Project Teams and CoPs worked to explore how this could be different in a new service, for example, by reframing 'challenging' behaviours and 'resistance' to services as adaptive responses to the impact of abuse.

Useful identified approaches to embedded flexibility were explored in the research. These included:

- Exploring sustainable alternatives to time limited service provision, ensuring enough time is allocated for developing trust and connection with a client and not rushing to discharge.
- Flexible work including appointment times and locations and being responsive in times of need.
- Embedding choice and flexibility for survivors rather than a one size fits all approach, avoiding assumptions of what survivors will need.

Practice examples highlighting a flexible approach

Scenario 1 (Site 2): A survivor with an intellectual disability was referred to the ASP Local Project Team for flexible support that was identified as outside the capacity of the mainstream Sexual Assault Service. Flexibility was supported by:

- Offering outreach appointments in a location of the survivor's choice, including 'walking' counselling sessions in outdoor areas.
- Ability to have family members and disability support workers present during sessions.
- Support and advocacy through court processes, including physical attendance from the ASP Local Project Team staff member across several days and practical assistance with accommodation and transport for the survivor.
- Authorisation for the ASP Project Team staff member to work outside of business hours to attend a legal meeting with the survivor.
- Provision of specialist consultation and support to disability and education service providers to increase their capacity to support the survivor.

Scenario 2 (Site 1): a flexible approach to working with mental health noted that survivors who are framed as being 'too acute', e.g., high risk or repeat presentations to the Emergency Department, would previously have been transferred to a Mental Health Acute Care Team and discharged from another service. A flexible approach involved liaison with the Acute Care Team, Emergency Departments and Ambulance to provide a wrap-around response and the ASP Project Team staff member was able to continue working with the survivor.

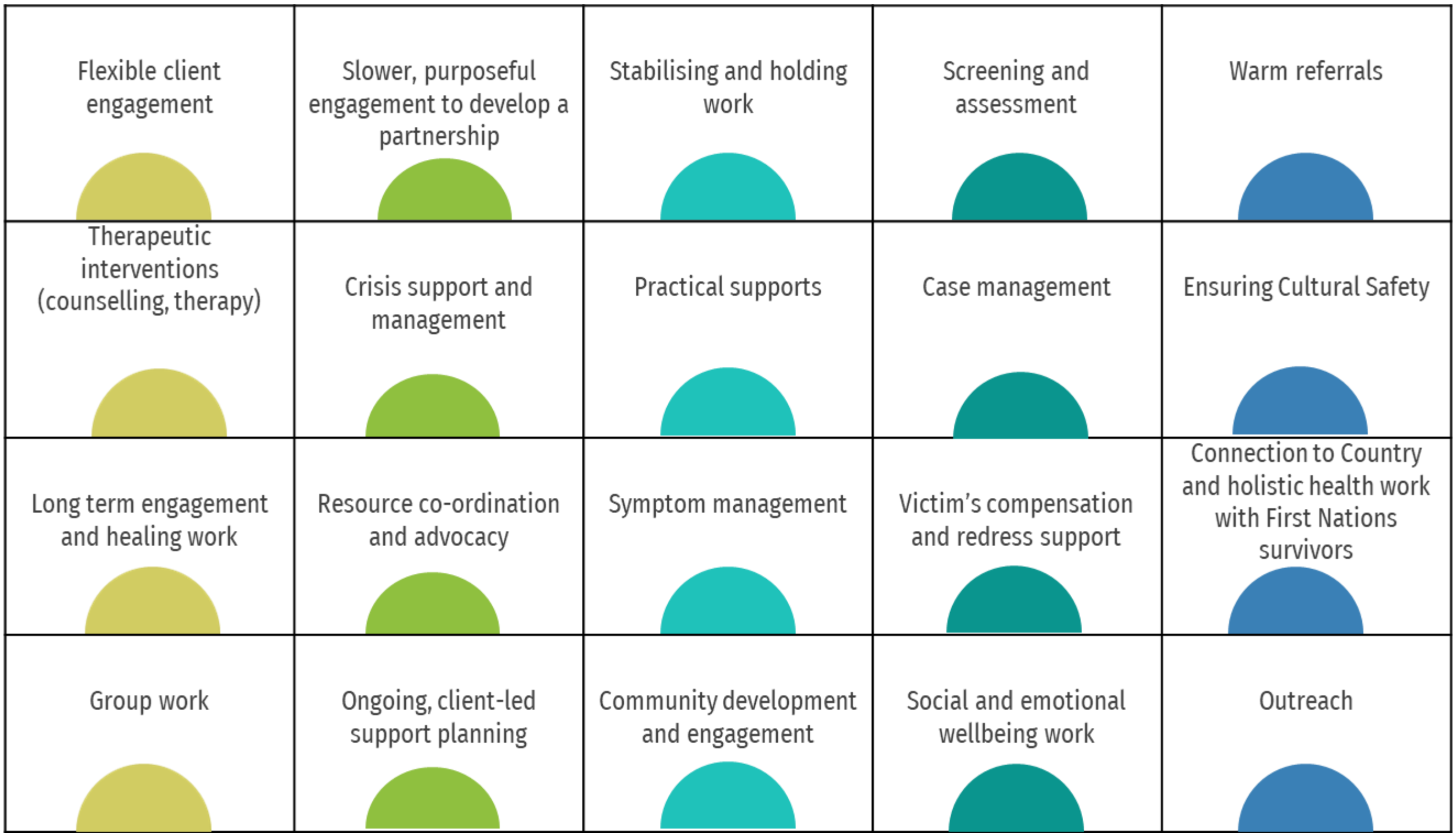
Developing a complete range of client responses

Moving from traditional counselling or crisis responses, the data explored the range and type of support that was helpful for adult survivors. Key elements of the client-centered approaches included:

- Expanding ways of working with trauma and abuse beyond long-term talk therapy or specific modalities.
- Recognising 'windows of opportunity' for healing in any interaction with a survivor, regardless of timing and context.
- Viewing Aboriginal health holistically, encompassing mental health, physical, cultural and spiritual health and wellbeing and responding to all of these aspects in a holistic way.
- Using the framework of adverse childhood experiences to identify survivors early in the engagement process.
- Focusing on strengths and periods of stability that could be built on, not just responding to crisis and risks.
- Understanding and responding to the challenges of working with adult survivors who are involuntary or under pressure to engage with services.
- Shifting away from 'quick fixes' towards asking what is needed to achieve long-term change.
- Re-defining 'safety', what it means for the survivor and have the capacity to work with that survivor-led definition.
- Using learnings from child and adolescent services about wrap around approaches using relational strategies to address developmental trauma.
- Understanding and being responsive to the challenges of requiring 'stabilisation' in one area to address another (for example, having stable housing to address mental health issues, but also needing stable mental health to sustain a tenancy).
- Combining therapeutic case management with practical case management around needs such as housing, financial assistance, and social supports.
- Understanding the needs from priority population cohorts and tailoring responses according to those needs.

Components of direct service delivery

Across both sites, the range of direct client work developed included:



Flexible client engagement	Slower, purposeful engagement to develop a partnership	Stabilising and holding work	Screening and assessment	Warm referrals
Therapeutic interventions (counselling, therapy)	Crisis support and management	Practical supports	Case management	Ensuring Cultural Safety
Long term engagement and healing work	Resource co-ordination and advocacy	Symptom management	Victim's compensation and redress support	Connection to Country and holistic health work with First Nations survivors
Group work	Ongoing, client-led support planning	Community development and engagement	Social and emotional wellbeing work	Outreach

Figure 22: Components of service delivery

The type of the work undertaken with clients at both sites is described through the following two case studies.

Site 1 (SESLHD) Case Study

Teresa is a 26-year-old woman who was referred to the ASP Team by the Sexual Assault Service. Teresa experienced childhood sexual abuse from family members in her country of origin, before migrating to Australia. She had a history of involvement with mental health services and a diagnosis of Borderline Personality Disorder. She had previously been described by services as “hostile, aggressive, uncooperative and unlikeable”.

Teresa had recently been sexually assaulted, causing her to become homeless, feel suicidal, and use benzodiazepines and alcohol to cope. She had no support network and reported she felt she was “unravelling”. The ASP team identified that Teresa could have been referred to sexual assault, drug and alcohol, or mental health services, none of which were likely to meet her needs due to service gaps or rigid eligibility criteria.

The ASP team used the action research project to engage in critical reflection around challenging the idea of ‘deserving and undeserving’ clients or what constituted a ‘good victim’ and drew on the Community of Practice to consider new ways of working. The team conceptualised Teresa as a young woman experiencing impacts of cumulative trauma, abuse, lack of protection and support. The team identified the key goal as “establishing a safe and consistent relationship” for Teresa rather than targeting substance use or mental health concerns. Teresa was given choices about when, how and where she spoke with the team. She was able to miss appointments and was reassured that someone could talk to her when she was next available. There was no expectation of formalised care plans. It took several months of for Teresa to feel comfortable enough to provide her full name.

Teresa was allocated a key clinician to work with. The nature of support depended on Teresa’s needs at that time, and included:

- Regular contact: Phone and face to face outreach appointments (in public spaces that Teresa felt comfortable).
- Stabilisation: Safety planning, crisis management, support with distress tolerance skills development.
- Counselling: Psychoeducation around impacts of trauma, trauma-informed therapeutic support for sleeping difficulties, low mood, anxiety (without requiring diagnosis or psychiatric review).
- Practical support, case management and advocacy: Including Centrelink, Victims Services, employment services provider, general practitioner, housing assistance, a specialist NGO for survivors of child sexual abuse.
- Advocacy and support engaging with police and legal advice around reporting options.
- Liaison and advocacy with mental health crisis team and ambulance.
- Coordination of services including information-sharing, report-writing and consistent communication so Teresa felt empowered and did not have the burden of constantly advocating for her needs with different services.
- Recommendations around ongoing support through the ASP team and other services.

Teresa has been in regular contact for over 6 months. Over this period, she has increased financial security through Centrelink and Victim’s Services, has moved into private rental and started a small business reflecting her interests. She reports feeling better in her mental wellbeing with more purpose, motivation and hope. This has led to a decrease in distress, sleep disruption, suicidal ideation, and use of substances. She has also started attending groups at a local NGO to connect with peer support from other survivors of child sexual abuse.

Site 2 (MNCLHD) Case Study

The client was an older woman who was forcibly removed from her family when she was 8 years old as part of the Stolen Generations. She had been disconnected from her culture and country and it took her over 50 years to find her family and where she came from and belonged. She had experienced childhood sexual abuse while in a residential institution and was later subjected to domestic and family violence. She had also used alcohol to cope with the trauma impacts. When she saw a program on 60 minutes on the Royal Commission into Institutional Responses to Childhood Sexual Abuse, she decided to make an initial complaint to Police about the abuse. who referred her to the Adult Survivor Pilot team.

At first contact the wellbeing clinician acknowledged the disclosure and bravery of her decision. Initial conversations focused on providing information about the service including voluntary nature of engagement, privacy, confidentiality, safety and containment. The survivor reported past negative experiences at hospitals around her mental health and the clinician reassured her that the Cottage was community-based and alternative locations could be explored as needed. The wellbeing clinician acknowledged intergenerational trauma and the impacts of colonisation, oppression and structural racism. The clinician gained consent from the survivor to participate in a cultural consultation with Aboriginal Health Staff to promote cultural competence and safety within the therapeutic work.

The survivor was informed she was welcome to bring support persons and started to bring family members to the Cottage, including adult children and young grandchildren. Family members were supported to sit in the courtyard, within eyesight of the survivor, while the survivor attended sessions in the counselling room. She expressed that it felt comforting seeing her family while also being able to discuss sensitive topics confidentially. Over time the wellbeing clinician explored with the survivor inviting supportive family members into counselling sessions. The survivor identified it would be healing and meaningful to have her adult daughter attend a session. The survivor discussed this with her daughter and a telehealth session was conducted where she shared her experience of being reunited with her mother and the grief she held for her mother, herself, and her wider community. The adult daughter disclosed her own history of childhood sexual abuse and wanting to use the family session to disclose this to her mother.

A face-to-face family session was facilitated at the Cottage with the survivor and her adult daughter. The wellbeing clinician provided information about the impacts of trauma and discussed its legacy for the survivor, her children, and grandchildren. There was an acknowledgement of the grief and resilience in the room. The wellbeing clinician used techniques to assist with grounding and containment. She assisted the survivor to explain the significance of reporting to Police and provide information to her daughter about what to expect. The survivor's daughter used the session to disclose to her mother abuse she was subjected to by a former peer, and both were supported through understandable intense emotions. The session explored survival strategies both women used through their lives. The wellbeing clinician assisted the survivor and her daughter to make a support plan and explore needs and hopes for future healing.

The wellbeing clinician has continued to see both the survivor, and now her adult daughter, for counselling sessions. Further family work is being facilitated as both have said this has been healing for themselves and in their relationship.

Time and space considerations

> A place where it’s not just clinicians and clients, but a place survivors feel is their own. Where they can come, and their values, thoughts, opinions, and leadership are valued in creating that space. Not just what they can get from a clinician but rather growing, through their own leadership and voice.
>
> Non-Government Organisation Participant, Community of Practice, Site 2)

Traditional Health physical structures (buildings, clinics, inpatient settings) have at times been sites of abuse and secondary abuse for many adult survivors. Clinical hospital settings may re-trigger survivors. For example:

Feedback from the Survivor was that the new location felt safer and less overwhelming than the hospital. She stated that she used to feel “like throwing up” when coming to the hospital for counselling as the hospital setting was triggering for her (ASP Local Project Team, Participant Reflections, Site 2).

Space

The importance of having a safe space to work with the adult survivor came through strongly in the data. Creation of a safe space occurred in two ways. Firstly, the creation of a safe physical space to locate the new service and secondly, by meeting survivors where they were feeling both physically and emotionally safe, through out-reach to other services (such as NGOs), home visiting, meeting in a central open location, or walking whilst engaging with the client. The key elements of a space which would provide both physical and emotional safety included:

- A location in a community setting (non-clinical and not in a hospital).
- Ease of accessibility (access to transport, into the building).
- A culturally safe space, with considerations of negating past racist practices in colonised spaces.
- A dedicated space with intentional layout, design and visual cues.
- A space that is purposely designed to include whole of family work where the survivor’s family and support people could be included.
- Capacity for outreach or flexible appointment location.

Practice Example Site 2: Creation of ‘The Cottage’

The MNCLHD site secured a cottage that was in a quiet street in town. The space was designed to provide options of where therapeutic work could take place, in the traditional counselling room, a larger group room, at a table on a landing area outside, or in the backyard undercover yarning area. The garden and outside space is separated by a glass sliding door so that staff can work with a client whilst their family waits in the garden. They can still see each other and this space supports movement to work with the whole of family. The artwork has a significant role in creating a welcoming environment for Aboriginal clients and their families. For those who come to visit ‘The Cottage' the artwork is a talking point for visitors and clients.

We had clients with mental health and alcohol and other drug issues, who felt traumatised about experiences in hospitals. That impacts their ability for ongoing therapeutic intervention at hospitals, fear of being judged. Being in the community-based site opened up options, built capacity for them to join and build trust again. Opportunity as well to give options to clients, especially from an Aboriginal background. Where (a survivor) is in session, the *family wait in the backyard yarning area. The doors are open, but they can't hear anything. It's a flow on effect, they can see their family member is safe. Building safety in that respect. And for those who experienced sexual assault in closed spaces. … We can do that in here, different to hospital. In a hospital you have a lanyard, 6 keys, about 3 doors to go through to get coffee. It represents an institution. Here it's more homely. It's grounding*. (ASP Local Project Team, Reflective Consultation Group, Site 2).

Time

A more flexible approach to time was reflected through the data as being an important consideration in the development of a new service. This was in terms of the length of time a client could be connected to the service, valuing longer-term engagement, as well as service operating times. Data drawn from the CoPs highlighted the need to extend hours beyond the traditional 9-5, having the service responsive in the evenings and over the weekends. There were discussions around the importance of flexible support for survivors at key periods, including the holidays and periods of system-wide 'shutdowns.'

Survivor participation to guide the development of the service and client work: practice example from Site 1

SESLHD used their survivor participation strategy to guide the development of the service. The site worked with 11 Survivor Advocates, with 10 participating in an interview, 1 providing a written submission, and 1 survivor participating in a second interview. The participants included 7 women and 4 men. Two survivors identified as Aboriginal, 2 identified as LGBTIQ+ and 2 as coming from a Culturally and Linguistically Diverse background. The following table developed by the SESLHD ASP Local Project Team highlights how adult survivor's suggestions about direct work were fed into the development of the service.

Theme	Survivor Recommendation	Project Response
Clinical Skills	• Survivors recommended that workers have specialty training in trauma-informed care, the dynamics and impacts of child sexual assault across the lifespan, and the individual impact of sexual assault and trauma. • Survivors felt it essential that workers are experienced in practicing within the area of Violence, Abuse and Neglect (VAN), in particular Sexual Assault. • Create a sense of safety and trust; be flexible, reliable, and consistent. • Believe and validate the survivor's experience. • Create a safe place, space to talk, and ask the client: 'Do you feel safe to talk to me? Be guided by the client on how the conversation will flow. If the client doesn't want to talk at the time, provide them with a phone number and	Modification of clinician's position title and description to reflect trauma as a focus of expertise. Direct adoption of practices in service delivery: • Flexible, reliable, consistent approach to clinical work. • Time permitted to slowly build trust and establish safety. • Clinical care based on current identified need, with survivor voice central to

	reassure them it is possible to speak at another time. - Ask the client what they want and what they need. - See past the immediate presenting issue to discover the cause of the behaviour and actions. People will present to services as hungry, angry, homeless, or even drug affected. Workers need to be able to sit with or tolerate uncomfortable feelings that arise with these presentations. - Include ritual, ceremony, art, and visualisation, as options and in a variety of ways that are comfortable for survivors to engage with. - Offer long term support. Acknowledge that therapy and recovery can be a lifelong process. - Recognise and acknowledge that a client in emotional pain and distress may be seeking help. - Recognise that behaviours may not necessarily be symptoms of depression or anxiety but rather indicators of trauma.	development of response plan. - Flexible model of care based on client individual needs.
Clinical approach and therapeutic interventions	- Skill development including: grounding exercises, diversion tactics, distress tolerance and self-regulation skills. - Psychoeducation about trauma and associated impacts. - Group work and opportunity for connection. - Education about sleep hygiene and the impact of sleep on health. - Information and education sessions about mental health and physical health – access to exercise classes.	Reflected in direct service delivery and development of model of care. - Clinician capacity building in trauma-informed care and practice. - Sharing of learnings with Adult Survivor Project Community of Practice. - A commitment to client-centred practice.
Psychiatry, General Practice and diagnosis	- Support access to a psychiatrist who provides trauma-informed diagnosis, therapy, and who will bulk bill for regular appointments. - Support access to trauma-informed GP who will bulk bill. - Provide information and explanations rather than simply diagnosis and medication. Help the survivor to understand the neurological and physical impact of trauma.	Implement supported referral pathways.

Connection to Country for Aboriginal people	• Acknowledgement of colonisation, inter-generational trauma and ongoing racism. • Connection to country is important for recovery. *Because of the Stolen Generations, not all Aboriginal people will know where their country is. Many Aboriginal people are in different places on the identity journey. It is important to be sensitive when asking about country.	
Cultural diversity and Inclusivity	In order to provide survivors with choice and to build feelings of safety it is important to offer a service that is inclusive, accessible and diverse. This can be achieved by: • Providing a service that has staff from all genders. • Providing a service that is welcoming of all genders and sexualities; provide the option to have therapy with a person from the LGBTIQ+ community, or connect them with a LGBTIQ+ clinician external to the service. • Providing a service that is welcoming of people who are from culturally and linguistically diverse places, provide the option to have therapy with a person who is representative of community, or connect them with multicultural identified clinicians. • Ensuring there is diversity amongst service providers and increase clinician's knowledge of culturally appropriate services for referral options. • Supporting victim/survivors who are from different cultures, when talking with parents and family members, and disclosing CSA.	
Accommodation and housing	• Provide assistance in securing crisis accommodation at the time of hospital discharge (this supports stabilisation and recovery). • Provide assistance to navigate the supported accommodation system, securing housing, and connect with community-based housing support services.	Development of relationship with community-based housing service, such as Stepping Out.
Finances and employment	• Provide connection with, and/or information about financial counselling and services that	

	can assist with reducing debt and managing funds. - Provide connection with, and/or information about employment and training: information about how to access employment service providers, training courses, and free online training.	Consideration of broad needs for survivors that includes financial support. Service mapping for survivors to access training and other types of support.
Police	- Increase Police awareness of CSA, dynamics of CSA, and the impacts on adult survivors. - Provide a survivor with access to a counsellor at first point of contact with the Police. - Ensure Police advise a survivor that counselling services are available and provide information on how to access. - Have a pamphlet or flyer on display at Police station, with details of what support is available and how to access it.	Development of relationship with Women's Legal Service to explore ways to support survivors in the justice system.
Religion and community	- Build relationships with religious communities. - Encourage key community members to increase their knowledge around CSA and how to help survivors. This will help the information move through the community, increase awareness and build trust. This will increase the likelihood survivors will seek help.	Plan to extend COP to a broader community network. Engagement of religious communities can be included.

4. Learnings for developing a safe service for Aboriginal people, families, communities and staff

Learnings across the research that suggest survivor-led, holistic, flexible approaches to survivors were key to a service response and were supported by key Aboriginal stakeholders involved in the pilot. Embedding Aboriginal approaches to enhance social, cultural, and emotional wellbeing were only touched on in this project due to contextual and time factors. These initial findings described below came from the data collected for the ASP Research Project. They can be viewed as a starting point for further exploration.

Time considerations

It is critical to allow sufficient time for engagement, consultation and partnership building with local workers and communities. For example, Site 2 proposed an Aboriginal-led project, that was impressive and thorough. However, the timeframes that are imposed in any pilot process made it difficult to develop and implement the project as planned. This led to a decision to add the adult survivor service into an already developed Aboriginal Alcohol and other Drug and Mental Health Model of Care that was about to be implemented, grounded in long and inclusive Aboriginal community engagement. Because of the links between experiences of childhood sexual assault, alcohol and other drug use and mental health issues, this seemed a useful way to integrate these three health services. However, grafting a new element into an already thoroughly planned Model of Care was not possible in the time available and a decision was made to begin the ASP in Coffs Harbour. However, the commitment to Aboriginal consultation, partnerships and engagement was carried into this new iteration of the pilot, as described later in this report, and became one of the most impressive outcomes of the pilot on the Mid North Coast.

Approaching the work with purpose

The purpose. We know that some people think if we stick up an artwork that will do. But those pieces, and that one, it's a calming piece, has purpose. So understanding the purpose of cultural safety is key. The purpose of the environment is key. Tokenistic versus having a purpose.

Aboriginal Health Participant, Focus Group, Site 2

Rather than tokenistic approaches, which are often characterised by one off consultative efforts with tight time frames, the ASP Research highlighted that slow, well considered engagement and consultation with local people, communities and staff is essential to develop an understanding of the local need and the appropriate responses. Taking a broad approach, working in partnership with a number of local communities and key stakeholders is critical to gain a more holistic understanding of the multifaceted needs of adult survivors in the community. Key to the approach is the importance of ongoing consultation and co-design of new services with Aboriginal colleagues, partners, communities and families.

Not just one Aboriginal staff member. Not just speaking to one person. Bringing in lots of voices, bringing in community members, Aboriginal staff from other services, that is key. Not just one voice because you just get one view. Having multiple voices rounds the service up. I said I can provide my cultural understanding but that's personal, my view, how I was brought up (Aboriginal Health Participant, Reflective Consultation Group, Site 2).

Practice Example Site 2: Valuing local expertise, knowledge and wisdom

The ASP Local Project Team prioritised developing a safe space to house the new service. Refurbishment of the space aimed to make it inclusive and culturally appropriate. The aesthetics of the building and importantly the artwork were important to create safety. The ASP Local Project Team met with Aboriginal workers who provided guidance on how the space should look and feel. Work was undertaken to engage Saltwalter Freshwater Arts Alliance which is governed by ten Aboriginal Land Councils from Karuah to Coffs Harbour to complete Aboriginal artwork for the waiting room and counselling space. The artists' stories are displayed next to the artwork. The stories and artwork convey the journey of adult survivors following sexual assault.

We had artists come to look at the space, to hang the artwork. They commented it felt homey, inviting, not like a hospital space. Really a nice gentle space…And they looked beyond artwork, where people sat, the space outside, how nice and homely it felt. That's what they took away. It was about doing it with purpose. Even acknowledging the need for outdoor space… that outdoor space for family to be a support, separated but can see each other, was really important. Its more than an environment, it's about embedding knowledge into the model having Aboriginal components embedded (Aboriginal Health Participant, Reflective Consultation Group, Site 2).

Slower, safer, holistic support for adult survivors and their families

Developing a connection and trust

The pilot demonstrated that slower, longer engagement with adult survivors and their families was critical to build a connection to start to develop a trusting relationship. This is important for adult survivors who had in the past attended health services that have been the cause of the harm. In the recent formal apology on behalf of the NSW Health system to survivors of the Stolen Generations[14] it was acknowledged that many Aboriginal children who were born in or admitted to hospital never returned to their families and communities, with institutions managed by NSW Health playing a role in the forced removal of Aboriginal children and babies. The location of the cottage being away from the hospital was critical in this approach. The design of the cottage was a representation of the start of embedded cultural safety.

Acknowledging power imbalances

Open acknowledgment of past trauma and the inherent and real power imbalances were made explicit in initial sessions with adult survivors which went a long way to developing trust. Acknowledging past and current experiences of racism in Health services was key to the approach.

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[14] NSW Health formal Apology (2022). https://www.health.nsw.gov.au/aboriginal/Pages/formal-apology.aspx

Case example: Site 2

An adult survivor disclosed ongoing child sexual abuse while living in institutions following forced removal from their family and community. The adult survivor reported previous disappointment when previous counsellor's approaches didn't fit what they needed and expressed significant anxiety and uncertainty about attending the ASP service. The ASP Local Project Team staff member described their aim as 'flattening the power hierarchy'. This included acknowledgement with the adult survivor of the power imbalance in the worker/client relationship, open discussion of the worker's own cultural background, and restoring choice for the adult survivor in how, when, and if they engaged with the ASP service. The worker acknowledged in session the impacts of colonisation, oppression, and systemic racism, particularly in the survivor's previous experiences with Health services (MNCLHD Client Work Tool).

Working with the whole of the family[15]

> It brings everyone in in a different way.
>
> Aboriginal Health Staff, Interview, Site 2

If an adult survivor wishes to invite their family into the recovery work, the service needs to respond appropriately. The ASP Local Project Team on the Mid North Coast developed approaches that included working with family members (at the request of the survivor) to enhance holistic support for both the survivor and their family. By 'bringing the family in', strategies to address the impacts of trauma, in particular intergenerational trauma, could be developed in partnership with the survivor. It is key that the family decide what the support and engagement look like.

Case Examples Site 2: Working with the whole family

Case 1: An adult survivor started working with the ASP Local Project Team and identified that the worker was the first person they had shared their story with. The survivor asked to invite their partner to a future appointment for support to disclose the abuse they had experienced to the partner. The worker was able to support the survivor to share their story in a joint session, during which their partner disclosed they had also experienced childhood sexual abuse. The worker continually sought consent and confirmation throughout the session and if it was within the bounds of what felt safe for them both. At the end of the session they expressed gratitude and asked if they could continue further shared sessions. A shared emotional safety plan was developed to support them and more sessions were planned.

Case 2: An adult survivor started working with the ASP Local Project Team and used sessions to explore how their experiences of child sexual abuse had impacted on their connection to culture, family and community. The

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[15] **Disclaimer: The research only touched on this way of working due to engagement and time limitations. It must be emphasised that depending on who committed the abuse, involving family or part of the family may not always be safe. We are not proposing that it is always appropriate to include family and this approach needs more exploration.*

worker aimed to 'bring the whole family' into the room by working with the survivor as a parent and exploring how their relationship with their own children was impacted by their experiences of abuse. The survivor reported they felt safe and not judged by the worker and was able to speak about issues where they held a lot of shame, leading them to feel empowered as a parent. The worker also provided advocacy with statutory Child Protection services and Mental Health services acknowledging the need for integrated support and building shared language around the family's experiences.

Due to time and engagement limitations, the research only started to explore this area of practice. Some of the considerations and ideas for further exploration include:

- How does the impact of trauma affect children of adult survivors and how can a service best support the family? How does it affect parenting?
- How does a service respond to family member's disclosures in a culturally safe way? How do you work with the whole of the family, keeping everyone safe?
- How do services respond when the adult survivor does not want support, but their family members do?
- What support can be provided to families of adult survivors to heal and move forward?

Cultural safety

> I'm proud of the team, what they learnt, they do it without thinking about it, doing it without thinking oh this is cultural safety, they have it. Understanding how to bring this component in.
>
> Aboriginal Health Staff, Focus Group, Site 2

At the time of the pilot, both sites were developing their local Sexual Assault Services Aboriginal Action Plans (AAP), another NSW Health commitment in response to the Royal Commission[16]. Key to the work of the AAPs is embedding cultural safety and culturally safe practices in Sexual Assault Services. In SESLHD, the feedback from their consultative work with Aboriginal Health through the AAP process was to wait to engage with local Aboriginal organisations about the pilot so as not to overwhelm the resources of the Aboriginal Health and NGO staff.

At the MNCLHD, the work undertaken to develop their AAP work was central to the development of their *Model of Care*. The key features from the *Model of Care* that align with the findings from the ASP Research Stream about cultural safety include:

- *Staff are aware of the full history and impact of colonisation on Aboriginal people, from the perspective of Aboriginal people.*
- *Staff are aware of intergenerational trauma and its ongoing impacts, including the previous and ongoing role NSW Health has played in causing this trauma.*
- *Staff are committed to ongoing development of knowledge of the local Aboriginal communities.*
- *Staff understand the barriers to using mainstream services faced by Aboriginal people.*
- *All staff recognise the benefits of white privilege and are willing to name and confront racism against Aboriginal people* (MNCLHD Draft Model of Care).

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[16] NSW Health Sexual Assault Services Cultural Safety Roadmap (2022). https://www.health.nsw.gov.au/parvan/Pages/cultural-safety-roadmap.aspx

Practice Example Site 2: Cultural consultation in service development

Cultural consultation was embedded throughout the development of the MNCLHD ASP Service. ASP Local Project Team Members reflected that existing Health policies continued to be unsafe for Aboriginal communities and services needed to work differently. The ASP Local Project Team reflected this was a journey around being 'open to listening, and change'. Key areas of consultation included:

- Ongoing advice, guidance, and consultation from the MNCLHD Aboriginal Wellbeing and Violence Prevention Coordinator and MNCLHD Aboriginal Health.
- Overall governance through the Aboriginal Specialist Advisory Group.
- Consultation with local Aboriginal Community Controlled Organisations about culturally appropriate ways of working, building partnerships and the needs of survivors.
- Access to cultural consultation to guide direct client work with Aboriginal survivors, families and communities.
- Building in a yarning orientation and morning huddles for staff members to discuss cultural considerations, survivors attending the service on the day, and expected family supports.

Valuing Aboriginal workers and providing critical supports for their continuing work

> It is not that we don't care, we do. We are just incredibly time poor.
>
> Aboriginal Health Worker, Interview, Site 2

The research data highlighted that Aboriginal staff, both in Health services and NGOs are dealing with enormous demands for their expertise, time and knowledge. In addition to their employment positions, Aboriginal staff are members of, and have responsibilities in, their own communities. Workers also have to navigate systems marked by past and current racist practices and beliefs and are dealing with their own experiences of inter-generational trauma. Aboriginal staff also face the ongoing challenges of 'walking in two worlds.' This makes strong and flexible support structures and processes essential. For example, discussions with the Aboriginal Specialist Advisory Group, highlighted rather than formal debriefing and Employee Assistance Programs processes, an Aboriginal worker might need time to spend time on country, such as spending time by the river, to reflect and process the work.

The critical importance of local Aboriginal governance and ownership

A key learning from the action research project's work with continued guidance and expertise from the AH&MRC is the importance of structures developed and embedded to ensure appropriate Aboriginal representation, leadership and oversight of any new service development. In line with the section above *approaching the work with purpose*, it is important to include multiple local voices with differing points of view. The data highlighted that this can provide a good foundation to develop an effective and inclusive service for local Aboriginal people, families and communities. A local advisory group can provide the forum for these views to be heard and can become a site of co-deign processes. On the MNC, the Specialist Aboriginal Advisory Group provided advice and oversight to the work using their local knowledge, wisdom and expertise. This was important as engaging with the Aboriginal Advisory Group was about listening to the stories and wisdom from that specific community. There were learnings for the site about each community’s different stories and different safety needs that could be responded to through the ASP Project.

> We need to have embedded some overarching Aboriginal Governance of the project...Would want to see Aboriginal Specialist Advisory Group formed in each Local Health District where that there is Aboriginal oversight of the work.
>
> Aboriginal Health Staff, Interview, Site 2

‘It’s not just a chapter’ embedded responses throughout the service system.

The data from the ASP Research Project highlighted that culturally safe responses must be embedded throughout service delivery. Some of the key findings that support this approach include:

- Using respectful, collaborative and partnership-based approaches. For example: the way a project/service will ask for and receive feedback from elders in the community, and other clients of a service should be developed in a co-design process with local staff and the community.
- Working with Aboriginal Health as a key central point as they have the broader understanding of the Health space. Those staff must be supported to undertake the engagement and development work.
- Engaging Aboriginal Health in a central role to provide advice on who to contact and how in the local community.
- Learning from Aboriginal community organisations and workers with expertise in working with adult survivors of childhood sexual abuse with a collaborative approach to healing. In particular, organisations such as Kinchela Boys Home Aboriginal Corporation, Coota Girls Aboriginal Corporation, and Survivor and Mates Support Network were identified as supporting safe approaches to working with survivors.
- Acknowledging the inherent challenges where non-Aboriginal structures provide the context for community engagement, which is inconsistent with principles of 'community control' and self-determination.
- Keeping all Aboriginal communities as key partners and developing community engagement and development strategies to enhance the partnerships. Engagement, developing trust and connections takes time and staff should be supported and resourced (e.g., time) to undertake the engagement work.

> We are told by our Aboriginal leads and experts, cultural considerations, it’s about everything we do, not just a chapter.
>
> ASP Local Project Team, Focus Group, Site 2

5. Re-defining integration: how can services collaborate by working at the intersections?

There are a number of terms used when referring to multi-agency or partnership work. These include: integration, coordination, collaboration and 'joined up' working. This type of coordinated work is often conceptualised as lying on a continuum. Horwath and Morrison (2007, p. 56) identify five levels of collaboration that range along a continuum from communication, through to co-operation, coordination, coalition and integration.

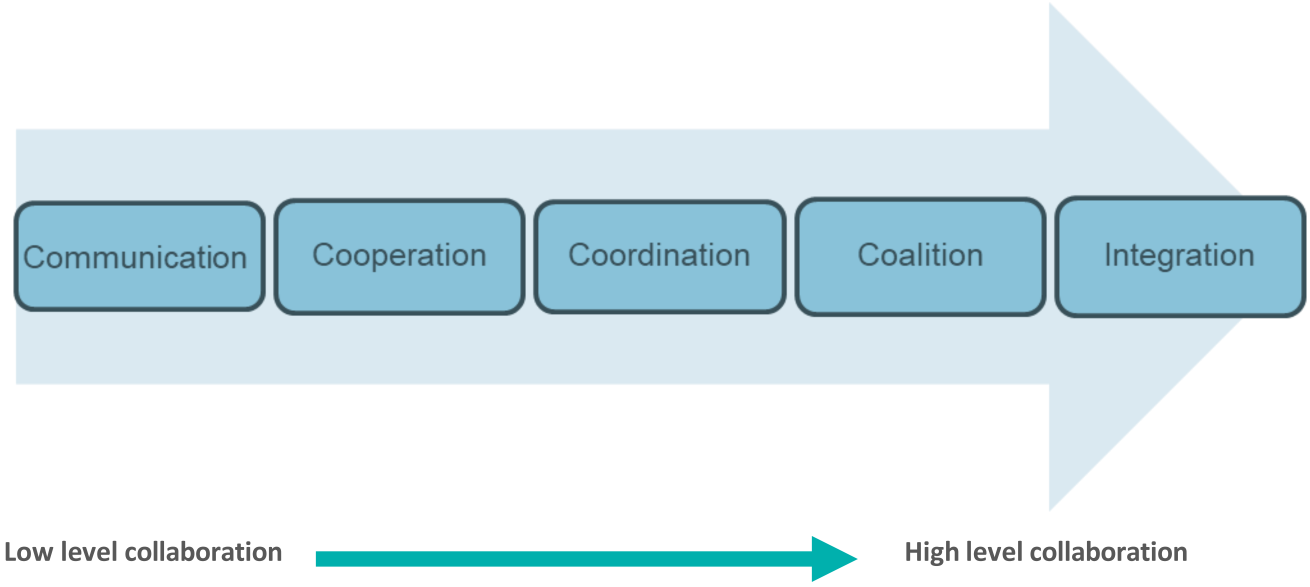


Figure 23: Collaboration continuum

Developing an 'integrated' service across the sectors: Mental Health, Alcohol and other Drug, Sexual Assault and Aboriginal Health in the project timeframe was ambitious. Any integrated approach requires a major cultural shift from all agencies or services involved and the stages generally move along the collaboration continuum from initial communication (starting to engage and talk with each other) to ultimately reach integration. The starting point in the pilot began with stakeholder consultation sessions to bring the siloed service sectors together to start a discussion. This initial communication started the recognition, understanding and acknowledgement of current challenges and how the work could begin across the silos.

The analysed data highlighted that an approach based on collaboration through initial communication and cooperation, through to developing strong partnerships, developing a shared language, and keeping the client at the centre of a wrap-around service model had more impact than trying to make the siloed service sectors fit together in an 'integrated way'.

> If other agencies are involved, there is a collaborative process so that everyone knows what is going on and understands their role, rather than trying to do it all or work in silos.
>
> (NGO Community of Practice Participant, Individual Reflections, Site 1).

Strong partnerships as a foundation

The data reinforced that the practice of building strong relationships as a foundation requires time, investment and a collegial sense of cooperation. A focus on practice approaches and the nature of the relationship as a valuable outcome in itself, was seen to open up new ways of working at the pilot sites. Important and integral to success of the partnership was a shared conceptualisation of goals, decision making, and understandings.

Strong partnerships were identified by the sites as the starting point of the collaborative work along the continuum. The data highlighted the key aspects to effective partnerships were:

- Genuine mutual respect from workers, not 'coming in as the 'expert' from a siloed space.
- Proactive collaboration and inviting people into a shared space for conversations and learning.
- A commitment to working flexibly from all partners.
- Starting small and local, identifying and working with key interested workers and agencies who could then broaden the scope out to other networks.
- Culturally safe engagement with Aboriginal communities, using key contacts and respected services, not coming in as the experts but with willingness to listen and learn.

> This is a slow process, it's not as simple as tick the box, what do you need and we supply that, but a place of negotiation, building connection and relationship... no one service holds the expertise. It's a backwards and forwards way of developing understanding.
>
> ASP Local Project Team Member, Community of Practice, Site 1

Practice Example Site 1: Innovative partnerships supported by the Community of Practice – working at the intersection of homelessness

In a Community of Practice at Site 1, there was a discussion about one of the projects the ASP Local Project Team had been engaged in which involved a collaborative partnership with a local NGO supporting people experiencing homelessness, the majority of whom were adult survivors. A senior worker from the NGO was a Community of Practice member. The ASP Local Project Team staff reflected that the NGO was 'encouraging us to be stepping out of our Health comfort zone' and prompted reflection on the culture and assumptions of Health services. The NGO reflected on their lack of resources and identified needs around capacity and how they have been building their response to adult survivors who make disclosures at their service.

Two areas of focus were identified to support a more integrated response – co-located direct client work, and the pilot team developing training packages for both workers and volunteers. While the direct client work did not proceed, the training packages were developed, implemented and evaluated across the course of the later Communities of Practice.

Partnership practice approaches identified from the data included:

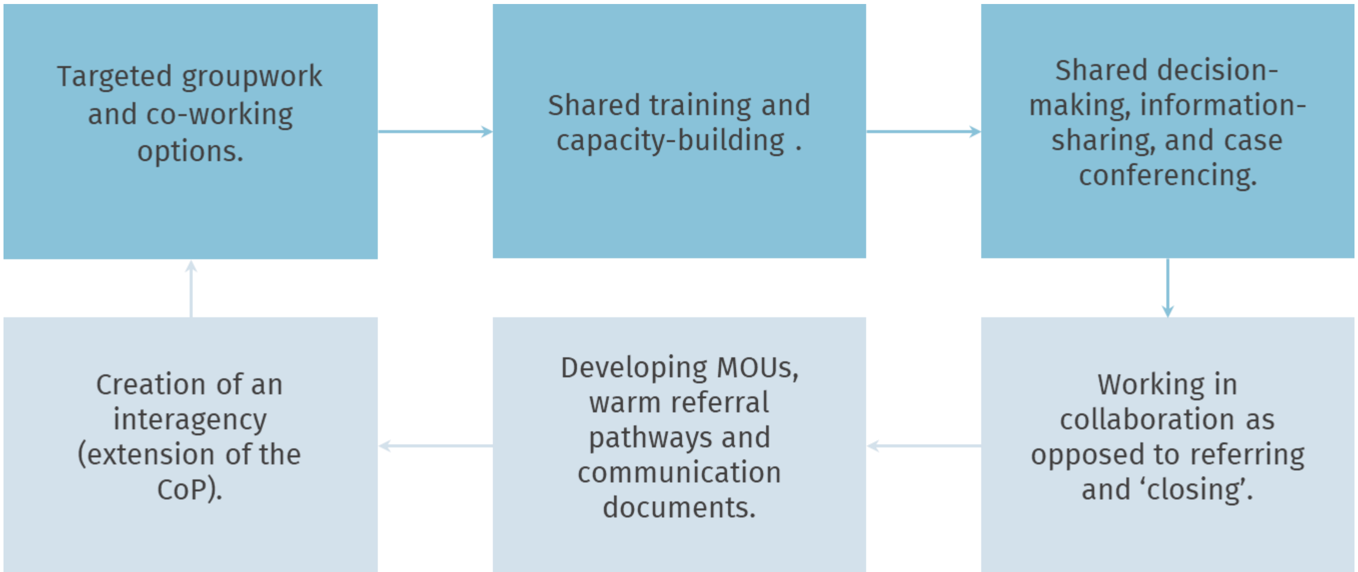


Figure 24: Partnership practice approaches.

Practice Example Site 2: Innovative partnerships supported by the Community of Practice – working at the intersection of domestic and family violence

Initial stakeholder consultation in MNCLHD focused primarily on Health services. The action research project identified a goal to increase integration with the NGO sector, particularly given the expertise of local organisations working with adult survivors. A local women's domestic and family violence service was identified as a key partner for the ASP Local Project Team. The partnership involved mutual consultation, relationship-building, participation in the Community of Practice, establishment of referral pathways and collaboration around direct client work.

The ASP Local Project Team reflected on learnings from the NGO around flexible working, developing a safe physical space, and working in a community setting. The NGO reflected that they work with many adult survivors who would benefit from specialist therapeutic support and were one of the first non-Health services to refer survivors to the ASP Local Project Team. The NGO and the ASP team developed a collaborative approach to working together to ensure 'wrap around' holistic support.

An understanding of trauma as a platform for collaboration

What became clear through the data was that a shared understanding of the needs of adult survivors based on an awareness of the impact of trauma was essential for the collaborative work. This allowed the sites to start to work across the boundaries imposed by how services are currently structured. Developing a shared language based on that understanding was essential for the service sectors to start to work together.

The partnership work, the development of shared goals and understandings, and the subsequent practical collaborative approaches *were the foundational steps to develop a collaborative approach to responding to adult survivors.*

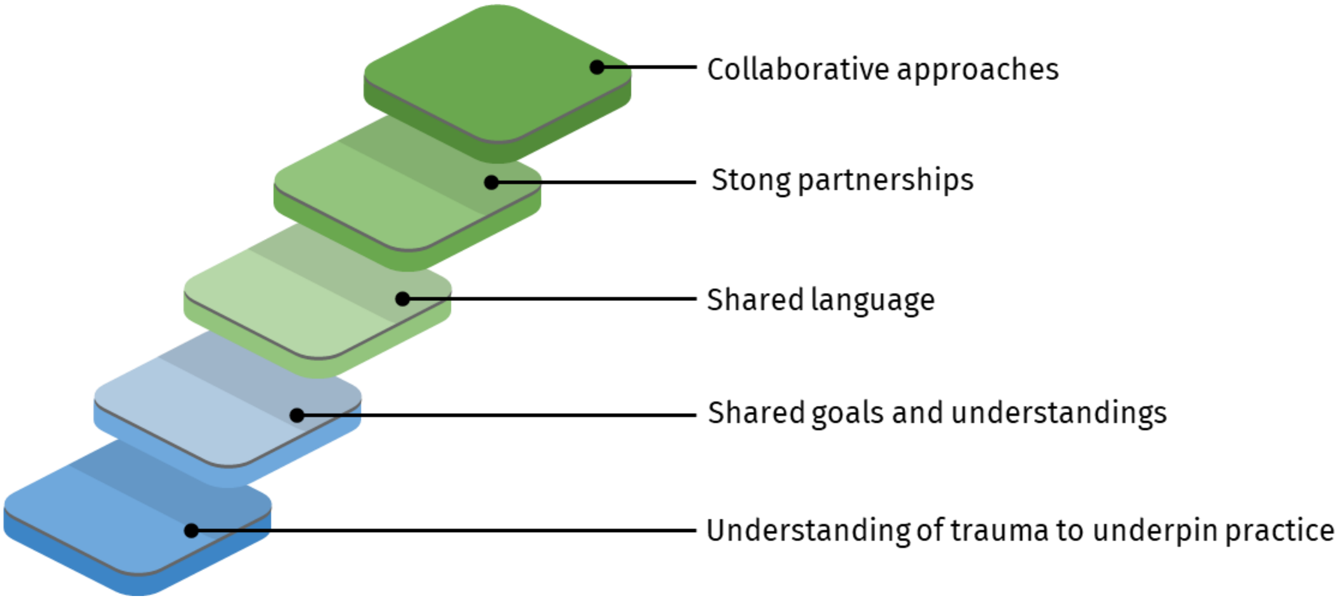


Figure 25: Foundations for collaboration

6. Capacity building and training to strengthen broader sector responses

Capacity building to support the system to better respond to survivors.

The Royal Commission identified that building better support systems and structures to wrap around adult survivors was key to reducing survivors ‘falling through the gaps’. The ASP Local Project Teams and CoPs explored the current system gaps and challenges in order to develop systemic capacity building responses. Findings from the data provided detail on the current support needs for the system and how these can be addressed through capacity building and training.

Support needs for the system

The data identified a number of challenges, as well as misconceptions from broader Health Services about how to best respond to the needs of adult survivors. The data highlighted significant gaps in understanding and practice skill across the service sectors.

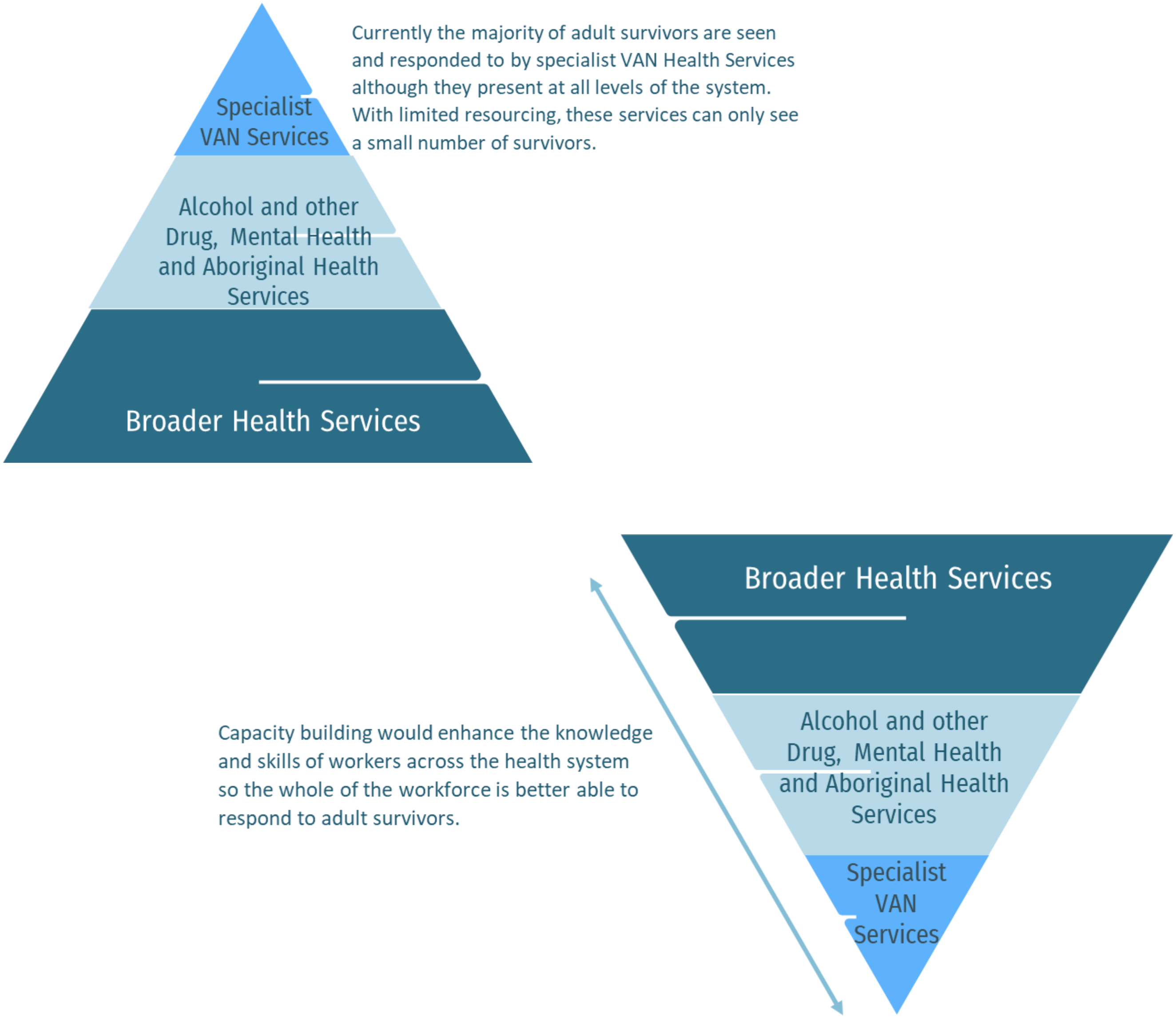
> **The system failed children who were abused and then continues to fail them as adults. We have a responsibility to advocate for this population.**
>
> ASP Local Project Team Member, Community of Practice, Site 1

The challenges identified were:

- Trauma informed practice was understood as needing to talk specifically about the adult survivor’s early experience of trauma. Workers felt anxious to talk about the details of the abuse with clients and at times avoided this, preferring not to ‘open up’ past experiences.
- Some staff felt unprepared for disclosures and did not feel they had the clinical expertise to assist. There was an assumption that specialised intervention should be the leading response and should be separate from mainstream clinical work.
- There was little or limited understanding of the intersections of childhood trauma with issues such as mental illness, alcohol and drug use, domestic violence, and developmental trauma.
- Workers often felt overwhelmed by the complexity of adult survivor’s presentations at Health Services and were looking for training and support to work with complexity.
- Trauma-informed rhetoric was often shallow without an understanding of how it worked in practice.
- A need for clear guidance on documentation of childhood sexual abuse.
- There was limited understanding of how to develop integrated co-work with a focus on ‘referral pathways’ instead.

Effective capacity building

By building the capacity of the broader Health sector, those adult survivors who are still unseen in the system would be more likely to receive a service response. The data identified that if workers across the system are skilled up in seeing and understanding the impacts of childhood sexual abuse and how these impacts present in a range of health settings, adult survivors will receive an appropriate and holistic response.



Currently the majority of adult survivors are seen and responded to by specialist VAN Health Services although they present at all levels of the system. With limited resourcing, these services can only see a small number of survivors.

Capacity building would enhance the knowledge and skills of workers across the health system so the whole of the workforce is better able to respond to adult survivors.

Figure 26: How capacity building can enhance service responses.

Opportunities for capacity building work identified in the research included:

- Developing better screening processes and opening up the conversations with adult survivors.
- Building workers' skills and 'tolerance' for working in the 'difficult areas' with adult survivors.
- Offering capacity-building as an alternative to 'referring on' adult survivors to separate service.
- Providing resources and supporting resource development in broader parts of the Health system.
- Co-location of a trained worker who is skilled and equipped to work with adult survivors on their complex needs in various parts of the Health system.
- Providing expert consultation to a range of services, primarily within Health, around specific 'cases'.
- Advocating for system-wide shared responsibility for survivors, *'working as a virtual team to support and implement changes for adult survivors'*.
- Exploring interagency group supervision, mutual consultation, and case discussions across the sectors.
- Exploring community development approaches.

Practice Example Site 1: Capacity-building through strategic influencing, and challenging systems

As part of their Consumer Participation Strategy, SESLHD used feedback from adult survivors to develop their capacity building work. The example of raising awareness of childhood sexual abuse (CSA) across the Health system is outlined below:

Feedback from local adult survivors	How the feedback was responded to and used for capacity building approaches
• Promote awareness of CSA at the community and individual level. • Increase knowledge of indicators of CSA. • Increase awareness of the ways CSA impacts on a person's life as they move into and through adulthood. • Help people to connect what happened to them as a child with how they are feeling as an adult.	• Development and delivery of CSA dynamics and disclosure training, for delivery to internal and external stakeholders. • Advocacy for client needs and awareness raising across multiple platforms including Mental Health Services and Drug and Alcohol services. • Presentation at Stepping Out CSA Awareness Week and other opportunities to speak publicly and raise awareness.

A focus on training to build capacity

> You need to learn a whole extra level of things to be able to work with the underlying issues.
>
> ASP Research Project, Survivor Advocate Feedback.

The data pointed to a number of training needs for both the ASP Local Project Teams as well as those working in the broader sector. It was acknowledged by research participants that increased levels of training would lead to more integrated responses and better outcomes for survivors. Areas for training were identified as:

- Responding safely to disclosures regardless of the service context.
- Understanding violence-informed as well as trauma-informed approaches.
- Distinguishing trauma-informed and trauma-specific practice and how to approach the direct work with adult survivors with a trauma- informed lens.
- Understanding trauma impacts for Aboriginal people, families, and communities alongside the impacts of colonisation and ongoing systematic racism.
- Understanding approaches to cultural safety and how to embed culturally safe practices.
- Foundational knowledge around childhood sexual abuse and its impacts.
- Effective advocacy practices.

- Building knowledge of alcohol and other drug use, and mental health, particularly for workers in Violence, Abuse and Neglect services.
- Intersections between childhood sexual abuse and other forms of violence.
- Intersections with child protection concerns and working with adult survivors as parents.
- Specialised responses for people living with a disability.
- Understanding behaviours within the context of abuse and survivors' resistance.

Practice Example Site 1: Survivor guidance on staff development and training.

Again, as part of their Consumer Participation Strategy, SESLHD used feedback from adult survivors to develop their training approaches.

Feedback from local adult survivors	How the feedback was responded to and used for training development
• Develop and deliver training in trauma-informed care; the dynamics and impacts of CSA across the lifespan; and the individual impact of sexual assault and trauma. • Ensure there is a broad network of people to receive training, not restricted to clinical staff. • Increase worker's knowledge of ritual CSA and the 'indoctrination that silences people'. • Increase clinical knowledge of CSA impact on sexuality and specific needs of LGBTIQ+ people. • Increase understanding of cultural impacts and culturally aware ways of working.	Development of suite of training workshops for delivery to internal and external stakeholders: • The Royal Commission into Institutional Responses to Child Sexual Abuse, and the Adult Survivor Project. • Adverse Childhood Experiences and an introduction to trauma-informed care. • Dynamics of Childhood Sexual Abuse and responding to disclosures. Training workshop piloted with Wayside Chapel. Commissioning of training development and delivery by SAMSN.

Practice Example Site 1: SESLHD training development and implementation *Partnership with the Survivors & Mates Support Network (SAMSN)*

The ASP Local Project Team partnered with SAMSN to develop a range of training options. SAMSN as an agency was built on collaboration between male survivors and professionals and operates within a trauma-informed framework. SAMSN created a number of new workshops to support the work of the Adult Survivor Pilot Project within SESLHD. It was designed for staff and services working with survivors of childhood sexual abuse. It aimed to build capacity in the workforce to support appropriate responses, support and resources for all adult survivors (all genders). SAMSN provided facilitators with both lived expertise and professional knowledge.

Practice Example Site 2: MNCLHD developing culturally safe services

The MNCLHD held a Cultural Immersion Day alongside the Aboriginal Mental Health and Alcohol and other Drug Team where all Violence, Abuse and Neglect staff attended. The day was held off site on Aboriginal land with a smoking ceremony and dance and Aboriginal bush tucker. The day was facilitated by MNCLHD Aboriginal Health staff from Mental Health, Alcohol and other Drug, Violence, Abuse and Neglect (VAN) and the ASP Local Project Team. Facilitated yarns on what cultural safety looks like now in VAN services and what action VAN services could take to enhance cultural safety going forward were key.

Cultural consultation, and growth of understanding of individual LHDs, understanding local context, local knowledge, historical impacts on Aboriginal people, what has happened. We have done that, local sessions, so clinicians have a sense of why Aboriginal people fear hospitals, authorities. Locally. That forms grounding and understanding (Aboriginal Health Worker, Reflective Consultation Group, Site 2).

7. A skilled and trained workforce

Clinicians working with adult survivors as facilitators of change: no longer ‘business as usual’

The data collected strongly reflected a need to move from traditional siloed health positions with specific sector expertise in one area (for example: alcohol and other drug clinician) to broader roles that respond to violence, abuse and neglect and draw on trauma-informed, culturally safe approaches and practices as the priority. A strong commitment to advocacy, community development and engagement, capacity building, understandings around cultural safety, and needs for priority populations, as well as direct client work were seen as key. An important finding was that the way that positions were designated within the ASP Local Project Teams were an essential step towards better collaboration/integration. Rather than thinking about integrating the service, the positions themselves became *integrated.*

Example from SESLHD: Review and changes to Clinical Position Descriptions

The MOH project funding had a clear objective to explore integration between the key crisis services (AOD, MH, SA) for better client outcomes. In SESLHD, the establishment of the initial workforce attempted to address this by establishing specialist roles within the team (AOD, MH, SA).

Once staff were recruited into these roles and client referrals commenced, it very quickly became clear that defining individual roles based on one field of expertise (e.g. mental health, drug and alcohol, sexual assault) was confusing for clients and stakeholders, in particular when referrals required access to each of these specialised clinical supports. The expectations of referrers and allocating the best clinician for the client became challenging for all involved. Clients required clinicians who could provide support and intervention to address all aspects of trauma.

In an attempt to provide integrative services to clients, the recruitment had unexpectedly further fragmented client experiences of trauma based on a service perspective rather than client need. The team had to re-consider roles and expectations from the client’s perspective and understand the client holistically; therefore provide a clinical team who could deliver a holistic response. I.e. intra-service integration was the first step before working towards better inter-sector and inter- organisational integration.

The first step to integration for the project team was to “de-silo” the project team. Team members moved from their original ‘expert’ positions into ‘trauma clinicians’ to work within a new trauma framework and also within a project context. Re-naming the positions to Trauma Clinicians was a significant and important project outcome and was achieved with the support and flexibility of the clinical team. Subsequent co-design work with Aboriginal Health has resulted in the Aboriginal identified positions to be title “wellbeing workers” ***Authored by SESLHD**

Identification, naming and prioritisation of ‘trauma’ as the service focus (rather than the anticipated focus of ‘sexual assault’) has been a key outcome that has influenced the position titles, positions descriptions and service direction. This distinction and change in language was endorsed by the SESLHD Community of Practice feedback, survivor advocates, key stakeholders and clients of the service. Expanding on this work to reflect Aboriginal perspectives which emphasise emotional and social wellbeing should be further explored.

Key skills and capabilities essential for clinicians working with adult survivors

> **Who can hold your story is also very important.**
>
> ASP Research Project, Survivor Advocate Feedback.

The action research process allowed for the capturing of data that described how the ASP Local Project Teams developed their workforce. Challenges that arose throughout the process were also captured. Key considerations when thinking about finding 'the right person for the job' emerged as a worker's: knowledge, background training; critical engagement, rapport and inter-personal skills; and personal and professional capabilities. These components are detailed below.

Content knowledge

- A strong understanding of intersectionalities including disability, sexuality, gender, culture and the additional barriers faced by adult survivors in diverse cohorts.
- A strong understanding of intersections between childhood sexual abuse and other forms of violence, abuse and neglect.
- A deep understanding of trauma and its impacts.
- An understanding of inter-generational trauma and the impacts of colonisation and ongoing and systematic racism.
- An understanding of healing and wellbeing frameworks and approaches.
- How childhood sexual abuse impacts on a survivor's mental health, possible life trajectory and possible alcohol and other drug use to ensure proportionate and appropriate responses.
- Approaches to interagency collaboration and knowledge of local systems and services.

Essential skills

- Skills in trauma-informed practices and comfort to work with the complexities of trauma.
- Skills to work with non-crisis driven culturally holistic therapeutic practices.
- Case management and co-ordination.
- Client advocacy.
- Systems advocacy.
- Skills to respond to the additional support needs for priority populations, with the ability to link to other services holding specialist knowledge.
- Community development and community engagement skills.
- Crisis intervention skills: the ability to work with clients navigating a number of "crises".
- Capacity to build relationships, trust and connections.

Worker capabilities

- Capacity to work flexibly and be client-led in practice: the ability to walk alongside and be led by survivors in decision-making, centering the client's choice along the journey.
- Capacity to navigate systems and operate on both a strategic and clinical level.
- Capacity to engage with First Nations social and wellbeing models and healing practices.
- The capacity to critically reflect on practice.
- Having a 'breadth' of experience across multiple service settings. NGO experience was seen to facilitate an ease of shift into the flexible client centered work.
- Including peer support roles and/or capacity for workers to facilitate peer support e.g., through groups, education, advocacy.
- Confidence to use professional judgment approaches.
- Going beyond a focus on traditional job descriptions and qualifications to consider the qualities, values, personal attributes of a worker who could appropriately support adult survivors with complex needs.

> So having a worker who can roll with the complexities of any human, not just a survivor, and be okay with that, and not personalise it, and be okay with, it's not black and white, be cool with the grey. Clients will not tell us everything, they don't have to tell us everything. They will give us the information they need us to hear at the time. And being mindful there might be more to the story but that's not important today.
>
> NGO Domestic and Family Violence Service Participant, Community of Practice, Site 2

Critical supports required for staff working with adult survivors

Workers from the ASP Local Project Teams reflected that within siloed services, they often experienced 'pressure to pivot back' to a single presenting issue rather than work holistically with the client. Workers noticed that if they were perceived as not addressing the presenting primary issue, they would typically be required to refer to another service and potentially discharge the client. For example, in the data set, it was seen that a Sexual Assault clinician was asked to refer to Drug and Alcohol services as the client was using alcohol and other drugs as they were expected to maintain their own sessions focused on 'sexual assault' alone. ASP Local Project Team members described in their individual reflections that it felt 'liberating' to have permission to explore a range of issues and work in a more holistic, responsive way with adult survivors.

The reflective data provided significant learnings about the support needs for staff employed in a 'new service' working with adult survivors. These are outlined below.

Support to integrate practice

> The employment of clinical roles specified to the silos we are trying to move across (SA, MH, AOD) was thought to be advantageous to the project, however the reality is that the clinicians embody the institutional, bureaucratic and siloed structures they have been part of for significant periods of time.... Attempting an integration project at this scale has had to start from within the team.
>
> ASP Local Project Team Member, Individual Reflections, Site 1.

Integration work is not fast or easy and the pilot aimed in some way, to begin to integrate distinct service sectors that have been traditionally separate. There was significant anxiety for staff to work outside of their specialised area. At times workers who came from the VAN sector felt anxiety about addressing mental health or alcohol and other drug use issues, and clinicians from Mental Health and Alcohol and other Drug services felt ill equipped to work with and address the sexual assault issues. This connected with the finding that Health clinicians were seen as having been 'deskilled' in integrative working.

The long-term results that I have seen through the recruitment of long-standing senior clinicians is that the structure of Health systematically de-skills practitioners to a narrow skill set within one aspect of the system (ASP Local Project Team Member, Individual Reflections, Site 1).

In response, the sites (both the ASP Local Project Teams themselves as well as management) spent a significant amount of time supporting staff through the integrated/collaborative work. Key staff supports included:

- Guidance around documentation. This included not being clinical or pathologising or focused on presentation and diagnosis but rather on the trauma impacts and prioritising a strengths based approach.
- Providing time and space for critical reflection and appropriate culturally safe and trauma-informed supervision.
- Providing adequately resourced training to support skill and knowledge development and quarantining time for professional development.
- Providing external and specialised supervision.
- Development of position descriptions to support the broadening scope: reinforcing that workers should not be left to navigate the complex work on their own.
- Creation of a new identity as integrated workers. For example: SESLHD renaming the clinical positions from 'Mental Health Clinician in the Adult Survivor Service' to 'Trauma Clinician' and 'Wellbeing Support Worker'. Development of new position descriptions was also necessary.

Support to work in a holistic way with the impacts of Childhood Sexual Abuse

Working holistically with adult survivors requires a range of skills and understandings. Depending on their experience and background, ASP Local Project Team staff required additional supports to further develop skills and knowledge in the areas which they had not worked before. For example, workers with counselling or psychology backgrounds required support and guidance to undertake effective case management and advocacy work.

Through the individual reflections and Community of Practice, ASP Local Project Team Members reframed services and the broader system as 'dysregulated' as an alternative framework to common discussions around 'dysregulated' clients. An example of this was discussions around a Community of Practice case study of a survivor who had received at least 8 separate mental health diagnoses over a period of 3 years. This led to a discussion around alternatives to pathologising including use of a dignity and respect-based approach.

> If we collectively, and by collectively, I mean seeping into other areas, resist the urge to pathologise and use pathologising language, that's a start in being respectful. People's behaviours are coping mechanisms, they're not diagnostic because they are not reflective of someone's inadequacies, or illnesses, or disease.
>
> ASP Local Project Team Member, Community of Practice, Site 1

Staff need the support, an authorising environment and the capacity to 'walk alongside' survivors on their journey in this way. In response, the following mechanisms were a way of providing support to staff to work across the complexities:

- Applying systems navigation as an essential component of the work – navigating, influencing, at times 'regulating the system' alongside or instead of regulating clients.
- Supporting staff to sit with discomfort, problematic or aggressive behaviour and holding a commitment to no 'undeserving' clients.
- Providing guidance around responding to crisis without being a crisis service.
- Supporting staff to work with diagnostic lack of clarity - rather than seeking resolution, working with the uncertainty or alternate frameworks.

Case Example Site 2: An ASP Local Project Team worker started engaging with an adult survivor with a history of involvement with Mental Health Services. The survivor had current child protection system involvement and was being mandated to attend Drug and Alcohol and Mental Health services. The worker advocated that this be changed so the survivor could instead choose to access integrated support through the ASP worker. Engagement focused on exploring how their childhood experiences of sexual abuse and other forms of violence were impacting them as an adult. The worker provided integrated counselling with a focus on validating the survivor's experience and responses and being led by the survivor around what goals and changes they wanted to work towards. Previously identified 'problems' as past survival strategies (e.g., self-harm, alcohol and other drug use) and responses to trauma (e.g., what was previously labelled as 'psychosis') were seen instead as experiences of shame in response to sexualised violence. A holistic approach also informed exploring cultural connection, spirituality and kinship support, which the survivor identified as being impacted by abuse and important for their healing journey.

Support to work in a culturally safe way

One of the key messages from the data was that the mainstream workforce cannot solely rely on Aboriginal colleagues to ensure culturally safe practices with clients and communities. The responsibility is everyone’s. Importantly, resourced supervision and consultation for staff as needed and the ability to work flexibly with whole family and communities is key. The centering of the LHDs Sexual Assault Services Aboriginal Action Plan is critical and will underpin the work. Cultural supervision is essential.

Support and permission to work flexibly

The data provided insights on how staff can work flexibly in a new service setting. A critical component of this work was that staff felt supported to do so. Workers often had a ‘false sense of safety’ in rigid models, criteria and policies. The ASP Local Project Teams focused on exploring other ways of supporting practice. Taking responsibility was seen as confronting at times. The essential ingredients for staff to work flexibly and creatively with adult survivors included:

- Being supported to adjust work arrangements to suit the needs of adult survivors without excessive bureaucracy. For example: including evening and weekend work.
- Working iteratively – being supported to critically reflect on the work undertaken in order to develop new and appropriate work practices.
- Support to work outside of a worker’s comfort zone, to think creatively to develop a client-centered response.
- An authorising environment that embraces new ways of working and putting those approaches into action.
- Both management and staff holding uncertainty and risk.
- Building staff capacity to use professional judgment (noting this was not just authorisation and support but re-training workers to develop this skill). When clinicians were supported in this way, they felt it was ‘empowering’ to be given trust/autonomy.
- Understanding that the impacts of trauma are not compartmentalised or linear, so standard referral processes, intakes, assessments, allocation and appointment scheduling may not be appropriate.

Working within a supportive team

The data from the sites highlighted team support requirements. A collegial and supportive team led to staff feeling equipped to provide direct client work where there was complexity. Alternatively, an unsupportive environment made the work more difficult. Key elements that are essential to support a team working at the intersections include:

- Developing shared project values, a shared language and a commitment to survivors ensuring everyone in the team has a genuine investment in the work.
- An understanding that team and service development is everyone’s responsibility.
- A move from a “sole worker” mentality to embracing a collegial team.
- For staff to have a feeling of being heard, listened to and validated about their challenges and concerns with the practice.

- Clinical, cultural, individual, and external supervision – especially someone as a 'neutral' person.
- Leadership and modelling of these new practices and ways of working from management.
- Management with skills in team formation, team cohesion, staff management, consultancy, project management, clinical supervision, systemic advocacy, and mediation.

Developing a hybrid position model: strategic and clinical/community expertise

The research highlighted that a dedicated role working with adult survivors required a mix of both clinical and strategic expertise and skill. It was seen that the dual role of direct work and strategic work would ensure staff would engage at both the individual and systems levels. Being a 'systemic thinker' and understanding systems change was seen as critical to enhance and support the work with survivors at an individual level. This would require engaging with work that is often seen as 'extra' in a traditional Health setting.

Practice examples across both sites: Supporting clinicians to engage in strategic project work.

Examples across the two sites included:

- Writing components of the model of care (MNCLHD)
- Developing and evaluating the consumer participation strategy (SESLHD)
- Participating in recruitment processes (MNCLHD)
- Writing communications documents such as a service newsletter (SESLHD)
- Engaging in stakeholder consultation and strategic partnership development as part of the project (Both sites).

Harnessing and supporting peer support roles

The importance of peer support work was raised through the Community of Practice meetings at both sites; however, this was an area identified as needing further exploration. Learnings from practices already in place included:

- NGOs offering peer support to adult survivors.
- Identified peer support roles in Mental Health and Drug and Alcohol services.
- Adult Survivor representation at an advisory level.
- Consumer participation strategies at Site 1 of the ASP.

Participants in the CoPs also discussed the need to build an understanding of what flexible peer support could look like within Violence, Abuse and Neglect services, noting this remains underdeveloped. Both sites identified a future goal to develop specific peer support roles.

It's also really important that [staff members] step out of an expert role, we aren't the only ones providing input… it was beautifully said that consumer participation is not doing for but doing with. Coming from that frame, you have to have survivors throughout. Anything new you do, because services are constantly evolving right, you need to be, it's not just something that's done as a piece of work and then left behind. That would demonstrate value in the survivor voice and real participation (NGO Specialist Service for Adult Survivors Participant, Community of Practice Discussion).

8. Sustaining system-wide change

> To achieve integrated practice and service delivery, there needs to be a greater shared responsibility to facilitate change. The establishing of a new team was never going to be enough to independently achieve change. This project is becoming the vehicle for highlighting the responsibility of all the parts. That is integration.
>
> ASP Local Project Team Member, Individual Reflections), Site 1.

The final reflective consultation groups held with the Community of Practice participants at both sites explored sustainability and how the advocacy, capacity building and systems change work could continue. The key messages from workers who had been part of the service development through the action research process highlighted the importance of:

- *Ongoing capacity-building and training* across sectors within Health around trauma-informed care and holistic and culturally safe responses for adult survivors. This should include universal training and professional development support for Health workers around complex trauma and childhood sexual abuse, responding to disclosure, First Nations' Healing Frameworks and social and emotional wellbeing models of care and practices.
- *Maintaining an authorising environment* that recognises the complexity of the work and supports staff through the provision of supervision, effective management, and appropriate resourcing. This authorisation should be at both Local Health District and statewide level led by the Ministry of Health.
- *Maintaining momentum* was seen as key. A commitment to a 'whole of system' response - sharing the work across the system as more effective than only funding a dedicated service to 'hold' working with adult survivors. Making responding to adult survivors everyone's responsibility – 'it's a whole of community response because the whole of community is affected'.
- Internal Health *data collection that focuses on outcomes rather than outputs*. There needs to be a move to include KPIs that reflect the nature of the work. The process, flexible ways of working and being responsive to survivors must be acknowledged in reporting mechanisms.
- A *commitment to supporting a cultural change* across health through addressing power structures within Health and past and present trauma caused directly by the health system to survivors – not just tokenistic but meaningful transparency and change.
- A continued *focus on the survivor 'journey'* from their perspective and conceptualising what trauma-informed, client-centered and culturally safe journeys would look like.
- *Replicating* aspects of the project that worked to support service development and systems change:
    - Community of Practice with Health and NGO partners
    - A strong focus on partnerships
    - Employment of joint clinical and strategic positions
    - Capacity to work and develop service response iteratively
    - A strong focus on consultation
    - Authorisation to work flexibly.
- *Long-term investment* in systems change to embed sustainability, including continuous learning and development as opposed to one-off training or investment.
- Support for *'slow' and mindful rollout* of new services to facilitate innovative, collaborative work and identify key areas where systems change is needed.
- Further inclusion of lived experience and survivor voices throughout the model of care, implementation and service development.

Section Seven: Discussion and recommendations

The Adult Survivor Pilot project used an action research approach to develop locally-driven, ground-up service models in two pilot sites in NSW. By responding to local and contextual needs, and through the action research process, the research team simultaneously collected evaluative data with the aim of identifying the core elements of effective service responses for adult survivors. This was a unique and innovative approach to the development of services within NSW Health.

The research also explored the capacity needs of the broader service system to enable it to better respond to adult survivors; the complexities that staff manage when working with survivors whose issues cross intersections; training needs; and whether and how a trauma-informed approach can build common understandings and integrated responses to survivors, regardless of their point of presentation.

The findings from this research were consistent with those of the Royal Commission, that is, the importance of: a flexible approach, collaborative practices, developing culturally safe services for First Nations people, families and communities, and responses embedded with a trauma-informed approach. However, the unique aspect of this project was eliciting data that explored developing these responses in a *Health setting.* The following learnings can be used to support broader state-wide implementation.

One size does not fit all.

Context is everything. A new service must be responsive to its own service environment. It is critical that unique iterations of the new service will reflect the demographics, contextual factors and needs of the local area. Key considerations about staffing, sector capacity, geography, client demographics, local community needs, local infrastructure and resources must be acknowledged and built into any new service model. This report recommends the critical components of a survivor service, but the ways in which these components are developed will be shaped by the unique service context in each LHD. Each service will need to engage and work with local community as each community is different.

Capacity building and training of the broader health sector is critical.

One single service in each LHD cannot provide services to the overwhelming number of adult survivors of sexual abuse requiring support, many of whom are already clients of health services. Survivors still remain hidden, trapped in the medical system and a silenced group. It is the critical that the broader health sector responds by recognising and responding to the impacts of childhood sexual abuse. The specialist adult survivor service has a vital role to play in mobilising broader Health Services and building their capacity to respond to adult survivors.

Workers across the system need to be skilled up in seeing and understanding the impacts of childhood sexual abuse and how these impacts present in a range of Health service settings. This is consistent with the goals of Stage 2 of the VAN Redesign Program[17].

The need to move from business as usual.

The new service requires a transformational shift from an emphasis on diagnosis and the expertise of the worker, to survivor-centred practices. This is consistent with the move towards trauma-informed care in NSW Health, where considerations of power and commitment to rectifying unequal power imbalances in the service/client relationship are key. The findings in Section 6.3 of this report provide a guide to this approach, which includes: moving to a client centred approach (away from service centred approaches), using strategies identified in the pilot and developing a service that is flexible and responsive with a complete range of client responses. Slow and considered engagement, coupled with a focus on developing a partnership with the client, should be the priority. KPIs and funding agreements must reflect this shift in focus of the work. Outcomes must become process driven, focusing on proximate changes for the client that add up to longer-term changes in the client's life.

Re-defining integration

The model of a collaboration continuum, which identifies five stages of collaboration - communication, co-operation, co-ordination, coalition and integration – provides a framework for understanding the processes of promoting services working together. Key to any successful collaboration is the development of a shared understanding of the nature of the issue to be worked on and the purpose of the collaboration. In this research, understanding complex, diverse and multiple survivor presentations through the lens of trauma impacts provided this necessary shared understanding, regardless of where the survivor presented in the health or broader welfare system. Trauma-informed and trauma-specific approaches provided shared language that was critical for the collaborative partnerships to begin to develop at the sites.

The Alcohol and other Drug, Mental Health and Violence, Abuse and Neglect sectors are entrenched in their own work cultures. Work to 'integrate' these 'silos' requires time, an authorising environment that strongly supports strategic level partnerships, a broader distribution of power, and a shift from the embedded culture of medical model approaches. Re-framing the service 'integration' across these sectors as 'collaboration' opens the space for services to retain their own expertise and approaches, whilst at the same time working on the shared issue and understanding of that issue.

Minimum components to develop a framework for practice

As each geographic area within NSW will be required to respond to local need and contextual factors, it is useful to identify the minimum components of effective service responses that were developed across the two sites in the pilot. These components can be used as a foundation for each LHD when developing their own locally responsive service responses.

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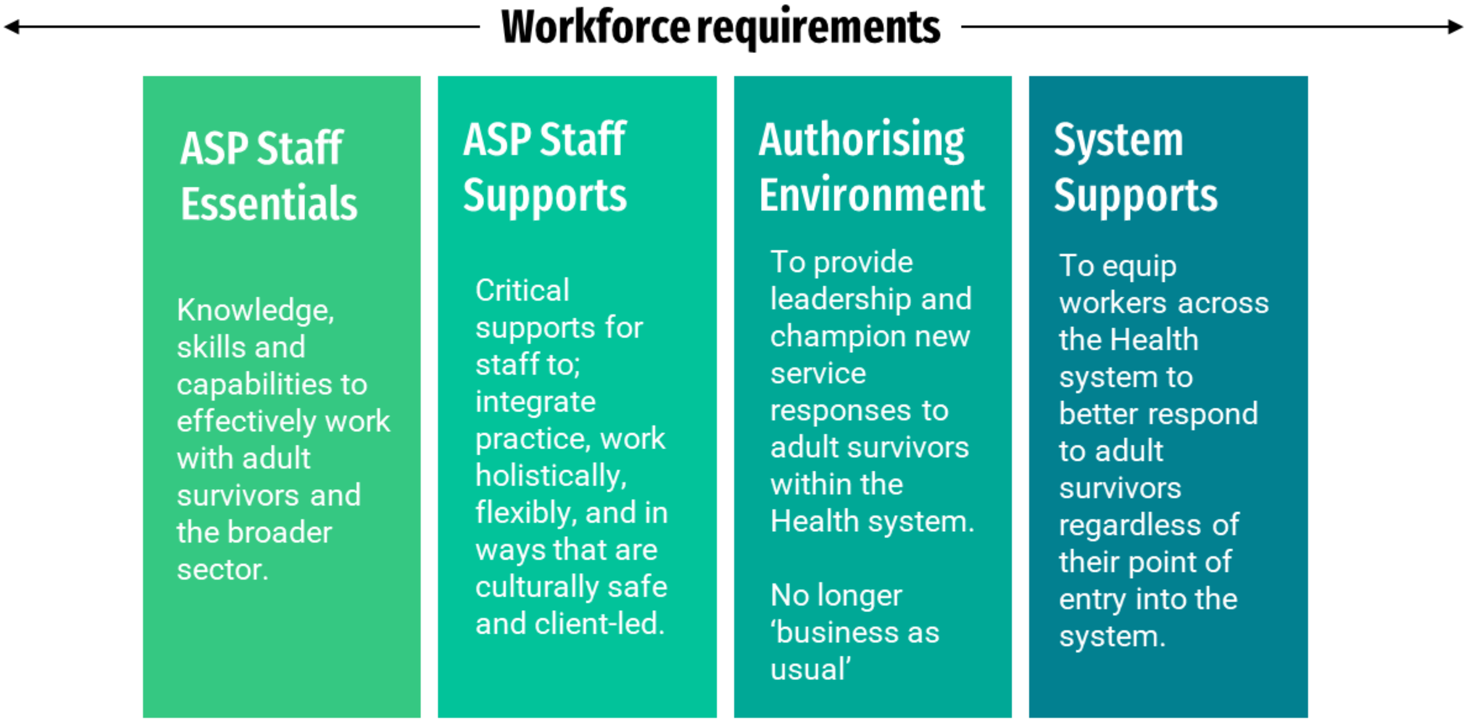
[17] NSW Health Violence, Abuse and Neglect (VAN) Redesign Program. https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx

1. Workforce requirements

When developing service responses for adult survivors, it is important to think of both staff of the new specialist adult survivor service, as well as the broader workforce within the Health system who regularly have contact with adult survivors. Staff working in the new adult survivor service team require targeted skills, capabilities and knowledge to effectively respond. To scaffold the work of those practitioners, critical supports that allow staff to work flexibly, holistically and in ways that are culturally safe and responsive, and client led are key. The diagram below highlights both the staff essentials as well as the necessary structural and system supports.



Workforce requirements

ASP Staff Essentials

Knowledge, skills and capabilities to effectively work with adult survivors and the broader sector.

ASP Staff Supports

Critical supports for staff to; integrate practice, work holistically, flexibly, and in ways that are culturally safe and client-led.

Authorising Environment

To provide leadership and champion new service responses to adult survivors within the Health system.

No longer 'business as usual'

System Supports

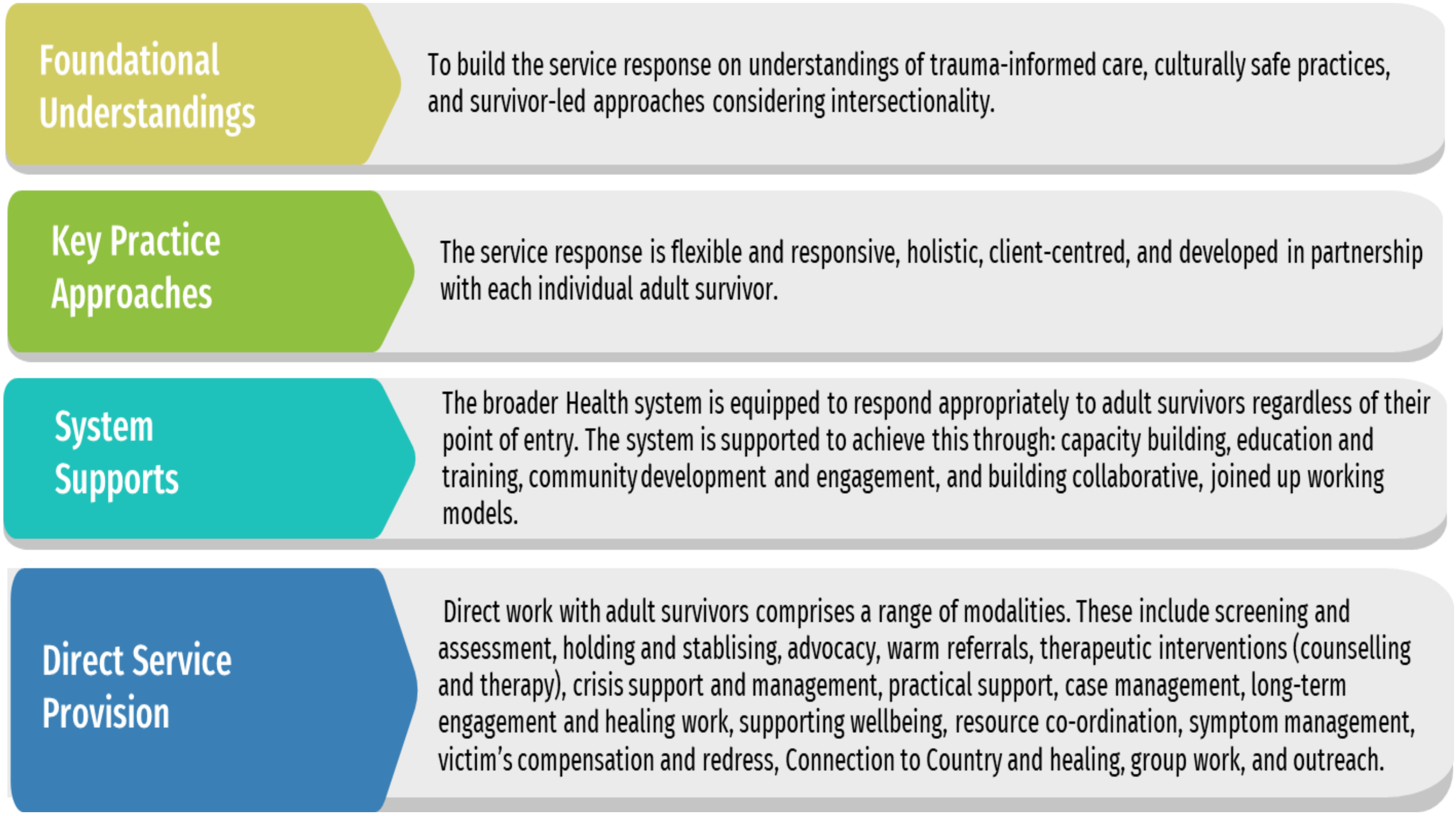
To equip workers across the Health system to better respond to adult survivors regardless of their point of entry into the system.

Figure 27: Workforce and system essentials

2. A practice response framework

The following diagram outlines the minimum components required for an effective service response across NSW Health for adult survivors. The components include:

- Essential foundational understandings and theoretical underpinnings,
- key practice approaches,
- supports for the broader Health system, and
- direct service provision modalities.



Foundational Understandings
To build the service response on understandings of trauma-informed care, culturally safe practices, and survivor-led approaches considering intersectionality.

Key Practice Approaches
The service response is flexible and responsive, holistic, client-centred, and developed in partnership with each individual adult survivor.

System Supports
The broader Health system is equipped to respond appropriately to adult survivors regardless of their point of entry. The system is supported to achieve this through: capacity building, education and training, community development and engagement, and building collaborative, joined up working models.

Direct Service Provision
Direct work with adult survivors comprises a range of modalities. These include screening and assessment, holding and stablising, advocacy, warm referrals, therapeutic interventions (counselling and therapy), crisis support and management, practical support, case management, long-term engagement and healing work, supporting wellbeing, resource co-ordination, symptom management, victim's compensation and redress, Connection to Country and healing, group work, and outreach.

Figure 28: A practice response framework.

Areas for further exploration

- Due to the time taken to develop the service responses in each LHD, it was not possible to evaluate the direct client work. The nature of practice approaches, particularly for Aboriginal people, families and communities should be explored further.
- Unlike many other pilots, this research did not evaluate the implementation of a pre-selected service model provided for piloting. Instead, the research team worked alongside two LHDs as they developed models of service that were selected through an Expression of Interest process run by the Ministry of Health. For this reason, this research did not address some alternative models of service provision that have been used to improve the response to other complex issues by promoting collaborative responses across sectors and organisations. Additional collaborative approaches could be explored further.

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