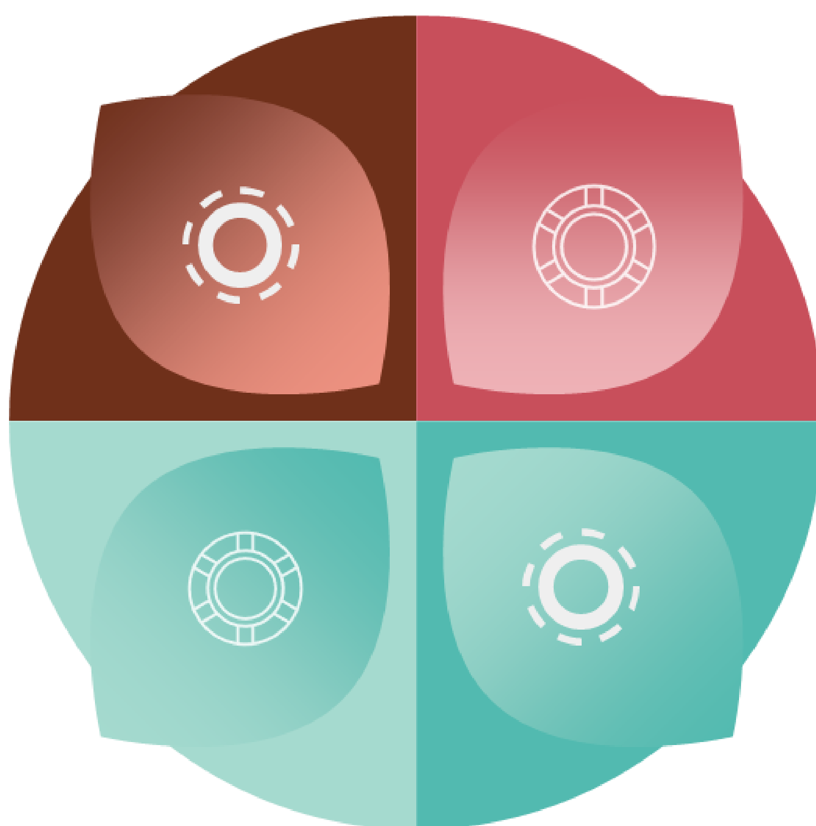
Responding to Adult Survivors of Child Sexual Abuse Across Three Distinct Service Sectors: A review of the current literature.



December 2019

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Suggested citation: Toivonen, C. (2019). *Responding to Adult Survivors of Child Sexual Abuse Across Three Distinct Service Sectors: A review of the current literature*. For the NSW Ministry of Health, Sydney.

SHPN (PARVAN) 230122

ISBN: 978-1-76023-445-4

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A note on terminology

In the violence, abuse and neglect sector, the term victim is most commonly used in public, legal and criminological discourse, while victim-survivor and survivor are used to reflect the process of victimisation and work survivors do to rebuild their lives after violence (Toivonen & Backhouse, 2018).

A person who has experienced childhood sexual abuse is referred to as an adult survivor in this review. Depending on context, this person may also be called a client or service user.

The terms: child sexual assault, child sexual abuse, and childhood sexual assault will be used interchangeably dependent on the context of the literature that the work was taken from.

Alcohol and other drugs, drugs and alcohol, and substance use and misuse will also be used interchangeably according to the source document the information was gathered from.

The terms men and women are used in this paper, again representing how they were used in the source document. We recognise that transgender and non-binary people's experience may not fit neatly and may require specific gender-sensitive responses.

For the purpose of this paper, the above terms are used interchangeably reflecting their diverse application across the sector.

Background

In 2019, as part of the Adult Survivor Pilot Project, CLT Byron Consulting was contracted to undertake a review 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.

SECTION ONE: Review of the Literature

A hermeneutic systematic review methodology (Boell & Cecez-Kecmanovic, 2014) was used to search for, review, and analyse the literature specifically related to best practice when working with adult survivors of childhood sexual assault who had experienced trauma through this type of violence and abuse, with a focus on mental health, sexual assault, and alcohol and other drug service responses. The interpretative approach of the search aimed to facilitate a meaningful synthesis and critical analysis of both academic and grey literature through interlinked cycles of searching and acquisition, and analysis and interpretation. The literature review involved a two staged approach: 1) a systematic search of journal articles; and 2) a targeted search of the grey literature.

1. Systematic literature search

The systematic search targeted research which provided qualitative and/or 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 service delivery responses. Collaborative and integrated responses were explored. A combination of search terms relating to: sexual assault, childhood sexual abuse, mental health, drug and alcohol, services, service responses, service provision, collaborative practice, collaboration, adult survivors of child sexual abuse, trauma-informed practice and responses, and best practice/responses were used and Boolean logic was applied in connecting terms. Search results were filtered to journal articles, abstract/title/keywords (depending on database and journal), English language, 2000-2018 publications (including articles in press), and relevant subjects.

Databases explored were: *Family: Australian Family & Society Abstracts, Aboriginal and Torres Strait Islander Health, DRUG Database, Australian Public Affairs, via Informit Online (1980 - present) (*which includes 96 related databases), *Social Services Abstracts* and *PsycINFO via OvidSP, Sociological Abstracts and Social Services Abstracts via Proquest, Family and Society via Ebsco Host* (which included 15 related databases)*, Web of Science*, and *Expanded Academic Index.* Specific Journals targeted and manually searched included: *Journal of Child Sexual Abuse, Journal of Family Violence, Trauma, Violence and Abuse, Australian Social Work, Sexual Abuse: A Journal of Research and Treatment*, *Child Abuse and Neglect, Sexual Abuse* and *Journal of Interpersonal Violence*.

A total of 4844 articles were found in the search. A rigorous screening process using the inclusion criteria below was undertaken. Articles were considered eligible for inclusion if they: (i) were peer reviewed, (ii) the full-text report was available in English, (iii) were dated between 2000-2019 (however, if the article was particularly relevant, this date was extended to include relevant articles from 1995), (iv) focused on collaborative practices and approaches, (v) highlighted good practice in service provision for adult survivors of childhood sexual abuse, (vi) explored gaps in service provision, (vii) highlighted trauma-informed responses in the collaborative space, and (viii) explored relevant integrated approaches.

The following articles were removed: (i) any duplicates, (ii) any correlation studies that focused on co-occurrence of mental health, drug and alcohol use as a result of the sexual abuse, (iii) articles outlining very specific therapeutic responses rather than over-arching approaches, and (iv) articles outside the specific date frame.

Overall, 83 articles matched the inclusion criteria and were used in the review.

2. Targeted literature search

The targeted search was designed to capture grey literature which may have not been found in the systematic review, such as government reports, inquiries, and service provider based responses to working with adult survivors of childhood sexual abuse. Websites for government, academic, and not-for-profit organisations and other related areas were searched. Both national and international web-sites were included. A snowball approach was used as more useful resources were discovered. A further 35 documents were elicited.

The following resources listed by NSW Health were also identified as being appropriate to include:

- State-wide Local Health District (LHD) VAN service profiles developed in 2018 as part of the Violence, Abuse and Neglect (VAN) Services Redesign Project which could potentially provide analysis of existing integrated practice between NSW Health sexual assault, drug and alcohol and mental health services and identify service gaps,
- relevant Royal Commission research and reports, and
- a review of the links and interdependencies with the Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

3. Analytical approach

In line with the process depicted below in Figure 1 (Boell & Cecez-Kecmanovic, 2014), the publications found in the search were examined to identify key concepts and findings which then enabled their classification into categories. This assessment enabled an identification of gaps in the literature.

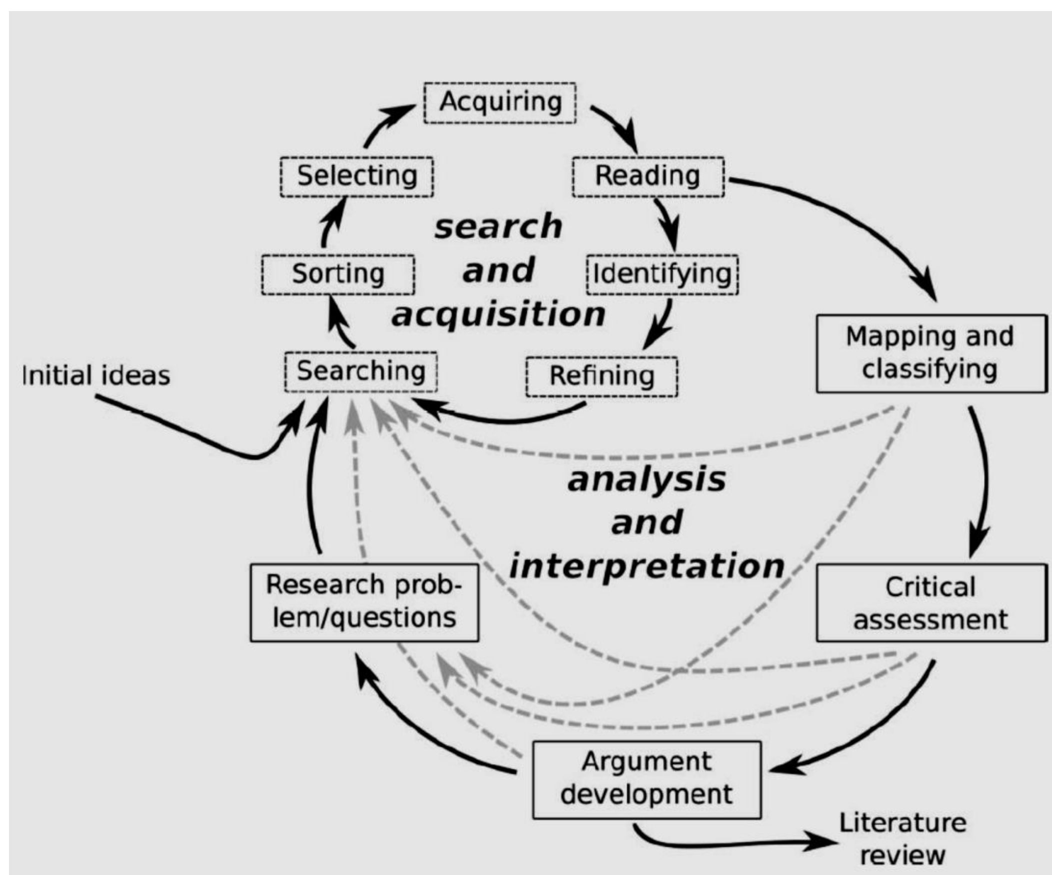

Figure 1. A hermeneutic framework for the literature review process consisting of two major hermeneutic circles (Boell & Cecez-Kecmanovic, 2014, p. 264).

SECTION TWO: Findings from the literature review

The findings from the literature review are presented in the following broad sections: childhood sexual abuse and adult survivors; impacts of childhood sexual abuse; considering mental health, drug and alcohol use and childhood sexual abuse together; limitations to current service provision for adult survivors of childhood sexual abuse; and how to overcome the barriers by considering elements of effective practice.

1. Childhood Sexual Abuse and Adult Survivors

Although this review does not set out to explore in detail both prevalence studies and literature outlining the impacts of childhood sexual abuse, or take a close examination of correlate studies, an overview is provided below to provide context. This is important as a basis for understanding how services can effectively work with adult survivors on their healing journey, whilst understanding how trauma is presented at entry points in service provision settings.

What is childhood sexual abuse?

The Australian Royal Commission into Institutional Responses to Child Sexual Abuse (2017, Vol. 2) adopted a broad definition of child sexual abuse that is victim-centred but takes into account legal definitions and frameworks. They state that child sexual abuse is:

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. (Australian Royal Commission, 2017, Vol. 2, p. 15).

Prevalence rates of childhood sexual abuse

Children and young people living in Australia experience sexual assault and abuse at high rates. The 2016 Personal Safety Survey (Australian Bureau of Statistics [ABS], 2017) collects information about women and men's experiences of abuse before the age of 15 years. Although not providing comprehensive data on all forms of violence, abuse and neglect involving children, this nevertheless provides valuable insights especially as it is a whole of population 'crime victimisation survey' that is the most comprehensive and robust quantitative survey of interpersonal violence in Australia (Cox, 2016, p. 2). It found approximately one in six women (16% or 1.5 million) and one in nine men (11% or 992,000) experienced physical and/or sexual abuse before the age of 15 (Australian Bureau of Statistics, 2017). When looking at sexual abuse, the survey found that 1 in 13 people (7.7% or 1.4 million) aged 18 years and over had experienced child sexual abuse. This included 1 in 9 women (10.7% or 1 million) and 1 in 22 men (4.6% or 411,800) (ABS, 2017). In Australia, the interim report of the Royal Commission into Institutional Responses to childhood sexual assault found that 1 in 3 girls and 1 in 7n boys had an experience of childhood sexual assault in their lifetime (Commonwealth of Australia, 2014). However, it is important to be cautious with these figures as they are

likely to be underestimations due to the difficulties around disclosing childhood sexual assault (Read, Hammersley, & Rudegeair, 2007)[1].

2. Impacts of childhood sexual abuse

There is an increasing body of evidence that highlights a 'significant link between a history of child sexual abuse and a range of adverse impacts both in childhood and adulthood' (Cashmore & Shackel, 2013, p. 2). The impacts are numerous and are articulated clearly in the work of the Royal Commission into Institutional Responses to Child Sexual Abuse (2017, Vol. 2). Systematic and meta- analytic reviews argue that childhood sexual abuse is associated with negative impacts to psychological, social, and emotional wellbeing (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013; Maniglo, 2012; DiLillo & Damashek, 2003; Paolucci, Genuis, & Violato, C. 2001).

In childhood, the longer the abuse goes on, the more serious are the effects. Cumulative harm, defined as 'the effects of multiple adverse or harmful circumstances and events in a child's life' (Australian Royal Commission, 2017, Vol. 2) has a significant impact on a person's life. In addition, effects may be exacerbated where the offender has a particularly close or influential relationship with the child, where the abuse is of greater severity, duration and frequency (Edwards, Freyd, Dube, Anda, & Felitti, 2012; Trickett, Noll, & Putnam, 2011), and, where the abuse occurs within institutional settings, when the institution fails to prevent the abuse or to respond appropriately after its occurrence (Smith & Freyd, 2013, as cited in Mathews, 2017).

Health and mental health impacts

When compared to community populations who have not experienced child sexual abuse, adult survivors of child sexual abuse have been found to have a higher risk of mental health issues which include; depression, anxiety and other affective disorders (Brown, Cohen, Johnson, & Smailes, 1999; Gilbert, Spatz Widom, Browne, Fergusson, Webb, & Janson, J. 2009; Harkness & Lumley, 2008; Kaufman, 1991 as cited in Wall, Higgins & Hunter, 2016); post-traumatic stress disorder PTSD (but contested as it doesn't include all the trauma impacts) (Kearney, Wechsler, Kaur, & Lemos-Miller, 2010); anorexia and eating disorders (Brewerton, 2007), self-harm and suicidality (Henderson & Bateman, 2010; Horvarth, 2010; Mullen & Fleming, 1998; Silverman, Reinherz et al. 1996; Thompson; Fry, 2001) and other somatoform disorders, psychotic and dissociative disorders including borderline personality disorder (Bateman, Henderson, & Kezelman, 2013; Breslaue, 2009; Nurius, Green, Logan-Greene & Borja, 2015; van der Kolk et al., 2009). Experiencing mental illness often coincides with other complex issues. This may be in part because trauma resulting from childhood sexual abuse is not associated with a unique set of symptoms (Kendall-Tackett, Williams, & Finkelhor, 1993) and often occurs in the context of other types of abuse (Briere & Elliot, 1993; Grossman et al. 2009).

Studies such as the Adverse Childhood Experiences (ACES) work (Centers for Disease Control and Prevention) also highlight that as well as mental health impacts, an adult survivor's physical health can be compromised through the effects of child sexual abuse and there are strong links with poor physical health outcomes such as increased risk for diabetes, lung disease, heart attack, and stroke (Widom, Czaja, Bentley & Johnson, 2012). As a result, adult survivors are linked to high rates of utilisation of health and other welfare services in Australia (Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2008; Mental Health Coordinating Council (MHCC), 2013). Institutions and services often struggle to provide support and respond to the needs of victims and others affected (Royal Commission 2017, Vol. 3).

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[1] For more information on prevalence rates and impacts of child sexual abuse see: Avoiding the 3 'M's: Myths, mistakes and misinformation in violence, abuse and neglect statistics and research (Costello & Backhouse, 2019).

Child sexual assault and alcohol and other drug use

Sexual assault and alcohol and other drug use have a complex association. It is clear from the research that many people with alcohol and other drug use issues have experienced interpersonal violence, including sexual and physical violence. The evidence suggests that all types of child maltreatment are significantly related to higher levels of alcohol and other drug use (tobacco, alcohol and illicit drugs) (Moran, Vuchinich, & Hall, 2004). The profound psychological effects of trauma resulting from abuse can often lead to alcohol and drug use problems in adolescence and adulthood (Fergusson & Lynskey, 1997; Harrison, Fulkerson, & Beebe, 1997; Perkins & Jones, 2004). For example, it is estimated that up to 80% of women seeking treatment for substance use disorders have histories of sexual or physical abuse or both (Cohen & Hien, 2006). Molnar, Buka, and Kessler (2001) found that the percentage of women with lifetime alcohol dependence was 16% among child sexual abuse survivors, compared with 8% for non-abused women. The frequency was markedly higher for men, with 39% of male child sexual abuse survivors found to have lifetime alcohol dependence, compared with 19% of non-abused men (cited in Cashmore & Shackel, 2013).

In addition, a history of childhood sexual abuse is correlated with more intensive patterns of drug taking and is associated with earlier use of licit and illicit drugs (Harrison, Hoffman, & Edwall 1989). Adult survivors are also more likely to use drugs more often and become poly-drug users (Harrison, Fulkerson & Beebe 1997; Bensley, Spieker, Van Eenwyk & Schoder 1999). Studies have also found an association between co-occurrence of a number of forms of abuse and poly-drug use (Harrison, et al. 1997; Bensley, et al. 1999).

For some adult survivors of childhood sexual assault, alcohol and other drugs play a functional role or provide a coping strategy that enables survival (Breckenridge, Salter, & Shaw, 2012). Research with survivors highlight that there are common reasons for using alcohol and other drugs, such as numbing and managing emotions, but also that substances may be used to manage nightmares and sleep patterns (Breckenridge, Salter & Shaw, 2012), to keep memories and flashbacks at bay in chronically unsafe or unstable situations, or to minimise trigger and startle responses (Padgett, Hawkins, Abrams, & Davis, 2006).

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 (Wall & Quadara, 2014).

While traumatic experiences can have serious consequences for adults, trauma that occurs in early childhood, particularly that of a sustained or chronic nature, has been found to be even more profoundly damaging (van der Kolk et al., 2009; Perry, 2006; Schore, 2001) because it fundamentally interferes with normal child development (Perry, 2006). Experiencing trauma as a child or young person through exposure to violence (Black, Woodworth & Tembley, 2012), being a child victim of violence, or a direct victim of abuse, is commonly referred to as developmental trauma or complex trauma (Ford & Cortois, 2009; van der Kolk, 2009; Bollinger, Scott-Smith & Mendes 2017; Price-Robertson, Rush, Wall, & Higgins, 2013). Complex trauma has been described as cumulative, underlying trauma (Kezelman & Stavropoulos, 2012). The impacts of both complex trauma and cumulative harm have the potential to stay with the child or young person as they move into adulthood (Black, Woodworth and Tremblay, 2012; Fox, Perez, Cass, Baglivio & Epps, 2015; Nurius, Green, Logan-Greene & Borja, 2015).

Adult survivors of child sexual abuse, often face extensive re-victimisation over the lifespan and poly-victimisation (co-occurrence of different forms of abuse) which is linked to complex trauma (Cashmore and Shackel, 2013). A number of studies have found that people who have been sexually abused as children are two to three times more likely to be sexually re-victimised in adolescence and/or adulthood than people not sexually abused as children (Strathopoulos, 2014; Cashmore and Shackel, 2013). The 2016 *Personal Safety Survey* found that 1 in 3 women (36% or 535,800) and 1 in 6 men (15% or 152,600) who have experienced abuse before the age of 15, have also experienced violence by a partner as an adult (ABS, 2017).

Collective and historic trauma for Aboriginal and Torres Strait Islander People and Communities

The causes of trauma for Aboriginal and Torres Strait Islander people and their families are significant and include impacts from: colonisation, displacement from land, institutionalisation, and removal from family (The Healing Foundation, 2015). Trauma experienced by elders, grandparents, aunties, uncles, and parents can be passed down to children through intergenerational or historical trauma - a type of trauma transmitted across generations (Atkinson 2002; Atkinson et al., 2010).

The trauma experienced by Indigenous people as a result of colonisation and subsequent policies, such as the forced removal of children, has had devastating consequences. The disruption of our culture and the negative impacts on the cultural identity of Aboriginal and Torres Strait Islander peoples has had lasting negative effects, passed from generation to generation. The cumulative effect of historical and intergenerational trauma severely reduces the capacity of Aboriginal and Torres Strait Islander peoples to fully and positively participate in their lives and communities, thereby leading to widespread disadvantage (The Healing Foundation, no date).

For Aboriginal and Torres Strait Islander people the experience of trauma as a result of child sexual abuse must be understood in the broader context of colonisation and the forced removal of children from their families, communities and culture. Dudgeon, Milroy, and Walker (2014) identify the nature of trauma in this context as 'the extreme sense of powerlessness and loss of control, the profound sense of loss, grief and disconnection, and the overwhelming sense of trauma and helplessness' (as cited in Ryan, Kelleigh & Hillan, 2016, p.8).

The Royal Commission (2017, Vol. 9) describe this type of trauma as 'collective trauma' which is also sometimes referred to as historical trauma, which is the:

cumulative emotional and psychological wounding, over the life span and across generations, emanating from massive group trauma experiences. It is a shared, unfolding grief and loss experienced by Aboriginal and Torres Strait Islander peoples. We use the term to refer to trauma caused by the decimation of Aboriginal and Torres Strait Islander populations during colonisation and the ongoing effects of this over many generations. This also recognises how destruction of language, culture, connection to Country and lore has disrupted social relations and healing practices integral to Aboriginal and Torres Strait Islander wellbeing. The sexual abuse of Aboriginal and Torres Strait Islander children in institutions is part of the experience of collective trauma (2017, Vol. 9, p. 22).

Dudgeon, Milroy & Walker (2014) explain how this trauma is further exacerbated through other life events such as: disconnection and alienation from extended family, culture and society; multiple bereavements and other losses; and the process of vicarious traumatisation where children witness the ongoing effect of the original trauma which a parent or other family member has experienced.

3. Mental health, drug and alcohol use and child sexual abuse: why thinking about addressing the three together matters

As authors Breckenridge and Salter highlight in a number of their papers on the intersections between childhood sexual abuse, mental health issues, and alcohol and other drug use, the relationship between the three factors is strong but 'complex' (Breckenridge, Salter & Shaw, 2010). These intersections and subsequent ways in which survivors present to the health sector create a complicated 'clinical picture' (Ibid. p. 17).

The following points highlight the importance of considering the intersections.

- People with histories of child sexual abuse are more likely to report problems associated with drug and alcohol use and misuse than those without histories of child abuse (Ibid, 2010).
- Conversely, those presenting to drug and alcohol services are more likely to report a history of child abuse than people in the community who have not experienced child sexual abuse (Ibid, 2010).
- Past victimisation may intersect with mental health issues and is often **exacerbated** by drug and alcohol misuse (Battle, Zlotnick, Najavits, Cutierrez, & Winsor, 2003; Sarteschi & Vaughn, 2010).
- Numerous studies have found that experiences of abuse are often associated with the development of anxiety disorders such as PTSD which can lead to abuse victims self-medicating with illicit drugs and other substances (Breckenridge et al., 2010; Forsythe & Adams, 2009).
- Substance users with abuse histories (including child sexual abuse) report higher rates of suicidal ideation and attempted suicide compared to users without such histories (Rossow & Lauritzen, 2002). This was particularly the case for those who have experienced multiple adverse experiences in childhood (Cohen & Hien, 2006).
- The linkages between abuse, mental health issues, and drug and alcohol use and misuse are particularly acute for women and require a gender-sensitive response[2] from services (Breckenridge et al., 2010).
- In the fields of substance abuse, users with additional mental health and other presenting issues are associated with poorer prognosis in substance abuse treatment (Covington, Burke, Keaton, & Norcott, 2008).
- Women with histories of child abuse and current drug and alcohol use can present with a number of pressing issues including: acute trauma-related mental health issues, child protection and parenting issues, participation in sex work and transactional sex to fund drug and alcohol use, heightened levels of depression, anxiety, somatisation, dissociation, phobias and eating disorders, sexual and physical victimisation in adulthood, histories of behaviours associated with risk, including sex work and/or sharing needles, and an increased risk of relapse, since drug and alcohol treatment is complicated by the presence of other psychological issues and needs (Breckenridge et al.,2010).
- The effects or 'symptoms' of abuse most often become the presenting problem for treatment or intervention rather than the childhood abuse itself (Breckenridge et al., 2010).

[2] Gender-sensitive care or responses are informed by knowledge and understanding of differences, inequalities and varying needs of women, men, transgender and intersex individuals and the interrelationship of gender identity and sexual preferences with childhood and adult life experiences such as abuse histories and experiences of discrimination; day-to-day social, family and economic realities such as poverty, housing situation and primary care of children; expression and experience of mental health and/or AOD issues; pathways to services, treatment needs and responses such as help-seeking behaviour and the type of service sought cultural and community background; and physical health issues such as risk factors and responses to medication (Department of Health Victoria, 2011).

4. Limitations to current service provision for adult survivors of sexual abuse

As outlined above, survivors of childhood sexual abuse will present to a number of different health services across their lifespan and have diverse and multi-faceted service provision needs. When thinking about developing appropriate response models for survivors of child sexual assault, it is firstly important to understand, acknowledge and then address the barriers that this cohort currently face when trying to access appropriate services. Unfortunately, the current research and literature paints a troubled and problematic service provision landscape for adult survivors. Survivors navigating the service system face barriers including:

- practitioners not making the links between child sexual abuse and their mental health issues or drug and alcohol use,
- compartmentalised service provision,
- sexual assault services not recognising and/or responding to mental health and substance use issues, and
- rigid treatment options (with a single treatment focus) (Breckenridge et al.,2012).

The following section highlights service and systemic barriers that adult survivors face when seeking help for the impacts of trauma.

A siloed approach

In Australia, increasingly limited financial resources, have moved health and mental health agencies towards a specialist rather than generalist focus, targeting client groups based on tight eligibility criteria. In this context, clients become multi agency problems as they move from agency to agency to have each of their issues dealt with. There is no suggestion that it may be the segmentation of service provision rather than the client that requires the multiple attendances. The splitting of issues into profession- ally defined service categories assists in obscuring larger issues (Gibbons, 1996).

Studies looking at the Australian health and welfare system often describe it as fragmented and siloed, with services frequently developed and funded to respond to single, discrete issues rather than being designed in a holistic way to address multiple needs for clients (Black & Gronda, 2011; Bromfield, Sutherland, & Parker, 2012; Shergold, 2013). This is particularly the case for adult survivors of child sexual abuse with complex health and mental health needs. This lack of integration creates barriers to providing a wrap- around, holistic response to the myriad of issues that survivors of child sexual abuse face (Asche, 2014). A siloed approach can also result in service duplication where the same needs are addressed simultaneously in different settings (Flatau et al., 2013). A devastating outcome of siloed working leaves survivors often falling through the gaps of service provision (O'Brien, Henderson & Bateman, 2007).

Despite the strong links between abuse histories, drug and alcohol use and misuse, and mental health issues, services in the drug and alcohol field are generally separated from providing mental health services. Conversely, survivors often face difficulties when trying to access mental health services and resources whilst working on their drug and alcohol issues. Alarmingly, research highlights that when clients were struggling with multiple problems involving mental illness and drug and alcohol use, they were often not seen as fitting the profile for either service (O'Brien et al., 2007; Breckenridge et al., 2012).

Within the drug and alcohol sector itself, services are siloed according to their focus. For example, services involved in inpatient services were described as having a strong emphasis on the 'medical model' (e.g., stabilizing medication) and the 12-step program, compared to those that emphasise therapeutic intervention, education and living skills. There is a lack of integration between the multiple models of drug

and alcohol services and lack of collaboration across the service sector itself (Breckenridge et al, 2010; O'Brien et al., 2007; Australian Royal Commission, 2017, Vol. 9).

Child sexual abuse as an underlying cause of trauma not being recognised by health services

The multiple and diverse impacts of child sexual abuse mean that survivors can present to a range of health services, but the links between their childhood victimisation and the presenting issues may not be recognised, resulting in a limited and ineffective service response (Alaggia, 2010; Osofsky, 2005; Taylor & Harvey, 2010). For example, Martsfolf et al., (2010) in their meta-summary of 31 qualitative studies exploring service provision for adult survivors of sexual violence found that health professionals ignored the history of sexual violence, especially in situations in which services may not appear to be directly related to the violence or doubted the story of the survivor.

O'Brien et al. (2007) also explored service provision for women who were adult survivors of child sexual abuse. They found that many psychiatrists held a belief that there was no link between the sexual abuse and the woman's current mental ill health. GPs often did not understand, and seldom asked about the possibility of childhood sexual assault, despite women presenting with a range of problems that may be indicative of trauma. Furthermore, adult survivors who frequently sought therapy from mental health professionals described experiences of mental health professionals not necessarily being aware of or trained in working with effects of child sexual abuse (Barber, 2012). In addition, mental health practitioner's asking about past histories of child sexual abuse is not routine practice (Mansfield, Meehan, Forward & Clarke, 2017).

Workforce issues

A number of studies highlight the difficulty for clinicians and practitioners to respond to the complexities of working with adult survivors in the current service landscape. Service providers report that due to an absence of adequate resources and a need to prioritise recent sexual assault victims, survivors increasingly experience ongoing barriers to access since they do not present in 'immediate crisis' at sexual assault services (O'Brien et al, 2007). A number of studies highlight that practitioners feel underqualified and under resourced to treat men with histories of child sexual abuse (Lab, Feigenbaum & De Silva, 2000) which unwillingly adds to the barriers men face in disclosing and receiving appropriate responses. In another study based on a sample of 54 British mental health professionals, a majority of participants reported feeling uncomfortable, insufficiently competent, and under supported in their work with adult survivors (Day et al., 2003). Other studies describe workers not being equipped to work with the trauma-related mental health needs of clients (Jonzon & Lindlad, 2004; Stojadinovic, 2003).

The above studies mirror results from further studies investigating responses to disclosure of sexual abuse (Agar & Read, 2002; Lab et al., 2000; Read et al., 2006) and implies a lack of capacity on the part of practitioners and services to effectively respond to and manage both adult survivor's disclosures and subsequent health and support needs.

Other studies which highlight the interaction between the adult survivor and service providers paint a worrying picture. One study describes survivors reporting that therapists failed to understand the violence which they found 'frightening' (O'Brien et al., 2007). Martsolf et al.'s (2010) study exploring interpersonal encounters with service providers state that these encounters were not always helpful in ameliorating the effects of the violence. Some practitioners seemed unable or unwilling to use their specialised training, knowledge, or job position to effectively help the survivors deal with or recover from the sexual violence. In some cases, participants indicated that the professionals lacked sufficient or current knowledge or training to adequately perform their jobs. Sexual boundary violations were described by participants in several studies.

Professionals who were unaware of, or lacked knowledge about, gender issues were problematic for survivors (Martsolf et al., 2010).

The difficulty of disclosure

Delayed or non-disclosure of child sexual assault is a consistent finding in the literature (Cashmore & Shackel, 2014), with estimates that 60–80% of victims never or do not purposefully disclose before adulthood (Alaggia, 2005). Disclosure of childhood sexual assault during adulthood is a multilayer diverse experience for survivors (Tener & Murphy, 2015). The majority of the literature exploring disclosure of child sexual abuse from adult survivors describes the overwhelming and numerous difficulties in disclosing the abuse (Sivagurunathan, Orchard & Evans, 2019; Orchard, MacDermid, & Evans, 2019; Australian Royal Commission, 2017, Vol. 9).

Common experiences faced as barriers to disclosure include:

- shame and fear of negative repercussions (Alaggia, 2005),
- lack of language to describe the abuse (Foster, Boyd & O'Leary, 2012),
- social stigma, previous negative responses and/or judgement from practitioners who survivors have previously told about the abuse (O'Brien et al., 2007),
- issues around masculinity (Foster et al., 2012),
- structural barriers in the healthcare environment (for example, service gaps function to limit disclosure amongst male child sexual abuse survivors as they may be uncertain what the next step in the disclosure process is once they have disclosed their abuse (Sivagurunatha et al., 2019), and
- relational challenges with therapists (Marsfield, 2017).

In their literature review examining studies around disclosure of child sexual abuse, Tener & Murphy (2014) indicate there are several individual, social, and cultural dimensions that impact the decision to disclose or conceal the abuse story. Interpersonal barriers to disclosing relate to all social systems surrounding the adult survivor: family, environment, society, and culture (2014, p. 5).

The decision to disclose or conceal CSA history is a complex, multifaceted, and measured process influenced by three domains: intrapersonal (individual's own feelings and reactions to abuse), interpersonal (the reaction of the social systems around the individual to the abuse), and sociocultural attitudes and stereotypes (Collin-Vézina, De La Sablonnière-Griffin, Palmer, & Milne, 2015; Dorahy & Clearwater, 2012; Tener & Murphy, 2015). There are further complexities around disclosure when thinking about gender and intersectionality. The research highlights that men wait much longer than women to discuss their abuse experience and are also less likely to access or be identified by support services (Foster, Boyd, & O'Leary, 2012; Hunter, 2011; Hunter, 2015; O'Leary & Barber, 2008) (as cited in Mansfield, 2017).

Although there is research which suggests that practitioners are getting better at asking about abuse in health care settings, there are still barriers to overcome such as a lack of appropriate response once the disclosure has been made (Sampson & Read, 2017). It is noted that clinicians also under identify child sexual abuse among men in mental health settings (Holmes & Offen, 1996). Delayed or nondisclosure may impede access to mental health services and other supports across the lifespan for men, thereby exacerbating mental distress (Easton, 2013).

A lack of understanding of the impacts of trauma

People impacted by trauma characteristically present at a wide range of services. They often have severe and persistent mental health and coexisting substance abuse problems and are frequently the highest users of the inpatient, crisis and residential services. Their challenges are often exacerbated by inadequate responses from

the community across mental health and human service sectors. (Mental Health Coordinating Council [MHCC] 2013, p. 24).

The literature highlights that in addition to siloed and often inappropriate service responses to adult survivors of child sexual assault, the availability of trauma-specific[3] psychological support remains inadequate (Asche 2014; Mammen, 2006; O'Brien & Henderson, 2006; Walsh & Douglas, 2010). This may be in part due to historical policy and funding priorities of Health and sexual assault services being based on responding to the immediate or crisis needs of recent victims, which has traditionally left adult survivors of past trauma out of the scope of service delivery (O'Brien & Henderson, 2006; Walsh & Douglas, 2010).

When looking at Australia's mental health system, it has been described has having, 'a poor record in recognising the relationship between trauma and the development of mental health problems, and hence in responding in an informed manner' (Mental Health Coordinating Council [MHCC] 2013, p. 23). The Mental Health Coordinating Council examined the reasons behind the lack of trauma-informed approaches and understandings. These include:

- the dominant use of the medical model and a 'diagnose and treat' approach (which fails to understand the underlying experience or trauma),
- resistance of medical professionals to believe accounts of abuse without substantiation,
- a culture of blame and pathologising of the victim, and
- the 'use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment, rather than empowerment and choice, often cause unintentional re-traumatisation in already vulnerable populations' (Ibid 2013, p. 24).

All of this can lead to secondary victimisation of survivors, when practitioners 'unwittingly take on an abusive role when they fail to recognise that the power differential inherent in the relationship between patient and clinician can mirror past abusive relationships' (Ibid, 2013, p. 25). The concept of secondary victimisation is described further below.

Secondary victimisation

There have been a handful of studies that explore adult survivors' experiences of health, mental health and drug and alcohol services (Asche, 2014; Chouliara, et al., 2012). The majority have reported that adult survivors have varying levels of dissatisfaction with current service provision, particularly tertiary hospital-based care (Clarke, 2008; Graham, 1994; Holden, 2002; O'Brien & Henderson 2006; Women's Health Statewide, 2005).

Asche (2014) in her study that examined support and service needs of young women who had experienced child sexual abuse, stated that many survivors seeking mental health treatment and support had experienced punitive responses to self-harm behaviours, treatment limited to pharmacological interventions, and inadequate support for their childhood trauma histories. Other studies highlighted the use of hierarchical treatment environments and experiences of disempowerment and powerlessness for adult survivors (Clark, 1998; Cox, 1995; Epstein & Wadsworth, 1994; Graham 1994; Lievore, 2005; O'Brien & Henderson, 2006; Women's Health Statewide, 2005). Studies also noted that psychiatric inpatient wards are particularly vulnerable settings for women with child sexual abuse histories, with the potential for re-victimisation

[3] A trauma specific service is one that is aware of the possibility of ongoing or re-traumatisation of clients and of the direct and indirect impacts on its staff and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients (NSW Health, 2019a).

resulting from aggressive behaviour, intimidation or sexual assault from others (Davidson, 1997; Graham, 1994; Victorian Mental Illness Awareness Council [VMIAC], 2008).

In drug and alcohol service settings, women who were survivors of violence who were not comfortable with the treatment regime, showed resistance to the process, or did not succeed in treatment, were seen as the failure (Salter & Breckenridge, 2014). In the mental health treatment space, Cognitive Behavioural Therapy (CBT) was specifically cited as one therapy where survivors felt that they had somehow 'failed' if they did not, for instance, cease self-harming (O'Brien et al., 2007). Survivors said that they felt they were *'being blamed if services do not work or are not appropriate'* (O'Brien et al., 2007).

Limited existing services

Alongside inappropriate, siloed or uninformed service provision runs the systemic and institutional barriers that create an unsuitable recovery space for adult survivors. These barriers include:

- long waitlists,
- verification of the abuse experienced required,
- requiring a referral,
- not providing services to men,
- service fees,
- communication issues, and
- lack of cultural sensitivity (Sivagurunathan et al., 2019).

Whilst the NGO sector clearly has taken much of the responsibility for providing holistic trauma based services for women survivors, they are resource limited. The Australian literature indicates that there is difficulty in accessing long-term affordable counselling, and a lack of support groups for adult survivors (Keel, Fergus & Heenan, 2005; O'Brien et al., 2007). Participants in O'Brien et al. (2007) study describe long waiting lists and being told, *'You are not a priority'*. Often participants came to therapy when they felt 'ready,' but were disheartened to find that they may have to wait for 18 months or more for one-to-one therapy. They did not want to have to *'tell the story repeatedly'* and found that the *'questioning of the validity of memories by therapists was very distressing'* (2007, p. 5). The same argument was made by the Royal Commission (2017, Vol. 9) which found that where specialist support was available, victims and survivors faced long waiting times to see a sexual assault worker which acted as a barrier to those seeking help.

Chaitowitz, Van de Graff, Herron & Strong (2009) undertook a mapping exercise exploring services for male survivors. Their study found that the majority of services were not-for-profit, designated sexual assault services. Services were found to be largely female-focused, with a clear lack of recognition of males as a specific needs group. Specialist services for key male subgroups were found to be very limited. Moreover, issues surrounding dominant constructions of masculinity were found to impact negatively on male access and disclosure to sexual assault services (Ibid, 2009, p. 28). Foster et al. (2012, p. 8) affirm this stating that, *'availability of services to assist men sexually abused in childhood is currently fragmented, with service access determined by which state or territory you are in, where you are in that state, and often influenced by whether a particular practitioner or 'champion' has taken an interest in the issue.'*

The lack of a policy response was found to be an overarching difficulty affecting all areas of sexual assault and childhood sexual assault service provision for males. Coinciding with this was practical organisational difficulties including a lack of funding, training, education, and male specific resources. There were also found to be a number of barriers relating to professional development and support, included a lack of internal or external group supervision and a lack of inter- and intra-organisation networking and coordination (Foster et al., 2012).

Additional barriers for Priority Populations

Violence, abuse and neglect are experienced by individuals and families across all of Australia's communities. However, there is clear evidence to suggest that particular groups of people and individuals experience multiple challenges that heighten the likelihood, impact or severity of violence, as well as experiencing additional barriers to seeking support and securing safety (AIHW, 2018; Backhouse & Toivonen, 2018; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) as cited by NSW Ministry of Health, (2019a).

Practitioners need to further consider barriers to disclosure and access to services for priority populations. A body of literature highlights both the additional victimisation and barriers to seeking help for a number of cohorts of people including: Aboriginal and Torres Strait Islander people (Funston, 2013), male survivors (Crome, 2006), LGBTQI people (Love, et al., 2017), young women (Asche, 2014), those abused in institutions (Easten, Leone-Sheehan & O'Leary, 2016), those who have survived ritual abuse (Matthew & Barron, 2015), women in correctional facilities (Strathopoulus & Quadara, 2012), new mothers and fathers (Stephenson, et al. 2018), and those from culturally and linguistically diverse and newly arrived migrant and refugee communities (Sawrikar & Katz, 2017).

Applying critical theory and a lens of intersectionality is key to understanding the compounding factors that play a part for these cohorts when both disclosing abuse and seeking support (Gruenfled et al., 2017). As such, more work and research is needed to explore the compounding impact of culture, gender- and race-based, and other systemic influences on child sexual assault disclosure and service delivery barriers.

5. How to overcome the barriers: considering elements of effective service delivery

This literature review confirmed that peer reviewed and evidence-based practice articles looking at collaboration or integrated service models encompassing the three service sectors: mental health, drug and alcohol and sexual assault were limited. Although there are a number of studies that explored current service provision for adult survivors of sexual abuse using a mental health and drug and alcohol service lens (Martsolf et al; 2010; Mansfield et al. 2017; O'Brien et al., 2007; Salter & Breckenridge, 2014; Sivagurunathan et al., 2019), a number of these studies highlighted the gaps and issues with current service delivery and subsequently made recommendations for a more appropriate and beneficial ways of delivering services to adult survivors. The limited number of articles describing integrated service models were in the context of sexual assault services for recent victimisation rather than for adult survivors.

As described above, a number of Australian qualitative studies have explored the service needs and support experiences of women with child sexual abuse histories (Holden, 2002; O'Brien & Henderson; 2006; Women's Health Statewide, 2005), while others have documented the needs of adult survivors of child sexual abuse as part of broader cohorts of women accessing services (Clarke, 2008; Epstein & Wadsworth, 1994; Graham, 1994; Hawthorne et al., 1996). The Australian Royal Commission provides a detailed examination on effective service provision for adult survivors seeking support. The report by Quadara et al., (2017) *Pathways to Support Services for Victim/Survivors of Child Sexual Abuse and their Families: Report for the Royal Commission into Institutional Responses to Child Sexual Abuse,* also highlights what types of services survivors had found helpful in their healing and recovery journey.

Elements of effective service delivery for adult survivors

As described above and as highlighted by the Royal Commission (2017, Vol. 9) adult survivors of child sexual abuse have multiple needs related to the impacts of trauma, requiring multiple levels and multiple types of

support throughout their lives. The current literature describes a range of practice responses and underlying philosophies of trauma informed work, that when used in a holistic integrated response, would ensure that the impacts of trauma are addressed for adult survivors. These responses range from practical support and advocacy, to particular types of therapeutic interventions and would depend on the need of the client considering a client centred approach (NSW Ministry of Health, 2019c). One of the key findings of the Royal Commission was that adult survivors needed 'special assistance', to navigate the numerous service systems that they came in contact with, and priority services such as access to housing, healthcare, education and mental health services.

The following section below describes the elements for effective and appropriate service provision targeted to adult survivors of childhood sexual assault.

The importance of trauma informed practice

Understanding that trauma underpins the presentations of many adult survivors who attend a range of service settings necessitates substantially new ways of operating. Many trauma survivors have not connected their current problems and behaviours with their past traumatic experiences and nor have their health or mental health workers. Work is moving towards an integrated and holistic approach to address trauma (NSW Health, 2019a) and trauma-centred practice should be embedded as an underlying principle of service delivery.

What has become apparent to services that deal with clients suffering multiple disorders and a complex array of trauma symptoms is that treatment needs are multifaceted and varied. Isolated treatment of trauma symptoms may only impact on one aspect of their needs. An approach to intervention that looks at encompassing the whole cluster of symptoms is more likely to facilitate sustainable improvement (Cohen & Hien, 2006 as cited in Wall & Quadara, 2014).

Trauma-informed models of care

A response to the siloed and disjointed responses to trauma are models described as trauma-informed care (TIC), but also referred to as a 'trauma-informed approach' or a 'trauma sensitive' practice. These models or approaches in essence aim to provide a safe, supportive environment to staff and clients that reflect available research about the prevalence and effects of trauma exposure and the best methods for supporting children and families exposed to trauma (Wall, Higgins & Hunter 2016, p. 96).

Quadara & Hunter (2016) describe trauma-informed care as responses that build 'an understanding of the traumatic impacts of victimisation into all levels of an organisation or system' including: at the systems level (targeting whole-of-system change or multiple organisations or services that serve a particular population); the organisational or settings level (that is, targeting an individual organisation or discrete setting); and the trauma-integrated interventions level (targeting service users)(2016, p. 19).

In addition, trauma-informed care involves recognition of lived experience of trauma and the particular 'triggers' that may lead to re-traumatisation and re-victimisation. In trauma-informed recovery-oriented services, care of people experiencing mental health conditions and associated difficulties must consider the possibility of trauma and its impact in relation to recovery (Victorian Department of Health, 2011, p. 7). A major development of sexual assault services has been the inclusion of a trauma-informed framework when assisting clients sexually abused in childhood. The language of trauma-informed care is now arguably the dominant means through which service providers understand the impacts of sexual abuse and sexual assault (Foster et al., 2012).

Hunter et al. (2016) in describing how services and organisations can be trauma-informed, believe that the agency, organisation or system needs to move through the following transformative steps to be truly considered trauma-informed: being trauma aware (seek information out about trauma), becoming trauma sensitive (operationalise concepts of trauma within the organisation's work practice), being trauma responsive (respond differently, making changes in behaviour), and ultimately move to becoming trauma informed (entire culture has shifted to reflect a trauma approach in all work practices and settings) (2016, p. 5).

The Royal Commission (2017) 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., p. 33). The Royal commission outline the key principles of a trauma-informed system of care which include:

- *having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and people's functioning;*
- *ensuring that organisational, operational and direct service-provision practices and procedures promote, not undermine, the physical, psychological and emotional safety of consumers and survivors;*
- *adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches;*
- *recognising and being responsive to the lived, social and cultural contexts of consumers (for example, recognising gender, race, culture and ethnicity), which shape their needs as well as recovery and healing pathways;*
- *recognising the relational nature of both trauma and healing* (Royal Commission, 2017, Vol. 9 p. 31).

At an individual level, The Substance Abuse and Mental Health Services Administration (SAMHSA) in their document *Trauma-Informed Care and Practice: A National Strategic Direction* (2014) describe working from a position of supportive neutrality.

Services must focus first and foremost on an individual's physical and psychological safety, and particularly respond appropriately to suicidality. They must also be flexible, individualised, culturally competent, promote respect and dignity, hope and optimism and be based on best practice. Recent research indicates that the most effective approaches for supporting recovery from trauma are well-integrated psychological/therapeutic health (SAMHSA, 2014, p. 28).

A developing body of literature has explored how trauma-informed practices impact on the adult survivor as a client. A review of qualitative and empirical studies found the implementation of trauma-informed frameworks in various support settings, including homelessness, mental health and substance-use services, was associated with more improvements for clients when compared to the usual treatment settings. These outcomes included significant reductions in psychiatric symptoms, a reduction in alcohol and other drug use, improvement in a client's self-esteem and sense of safety, a decrease in the use of acute or crisis services and increased satisfaction of service use (Hopper, Bassuk, & Oliver, 2010). The Women, Co-occurring Disorders and Violence Study (WCDVS), provides evidence-based studies of support for women with complex trauma (Cocozza et al., 2005). Women who accessed the nine sites providing trauma informed care showed a greater reduction in post-traumatic symptoms and substance-use issues than women accessing care in comparable settings involving usual treatment. An even more substantial reduction occurred in settings where the trauma model included integrated counselling (Cocozza et al., 2005).

Trauma-informed approaches for Aboriginal and Torres Strait Islander people and communities

Child Sexual Assault (CSA) in Aboriginal and Torres Strait Islander communities is a complex issue that cannot be understood in isolation from the ongoing impacts of colonial invasion, genocide, assimilation, institutionalised racism and severe socio-economic deprivation (Funston, 2013, p. 3818).

SNAICC et al. (2017) emphasise the importance of challenging deficit-based thinking by recognising Aboriginal and Torres Strait Islander cultural strength as a key protective factor against all forms of violence, investing in community-led, trauma-informed, cultural healing approaches, and valuing and building on worker expertise that is already in place within existing culturally appropriate frameworks and responses.

Funston (2013) in her work describing learnings from the *National Yarn Up: Sharing the Wisdoms and Challenges of Young People and Sexual Abuse,* describes the incredible complexities and barriers Aboriginal and Torres Strait Islander people face in their healing journey. Some of these include: that the western theories currently governing the child protection and health systems are both inappropriate and colonial; a lack of understanding of cultural and family dynamics; and shame, fear, and one way untrusting relationships with service providers. Ways to begin to mitigate these barriers include: decolonising services to create cultural safety within the system; dismantle the racist and historical belief that violence is a product of Aboriginal and Torres Strait Islander cultures; develop meaningful integration of Aboriginal and Torres Strait Islander Worldviews; understand and incorporate the interconnectedness with land-kin-spirit-culture in service responses; transform Western-centric bias in service delivery; and for practitioners and service providers to take a stand against racism and lateral violence.

Safety is the cornerstone of healing, and in practice, this means prioritising cultural safety alongside the physical safety of Aboriginal and Torres Strait Islander children and young people. For Aboriginal and Torres Strait Islander children and young people healing and justice cannot occur until sexual assault services become culturally safe. Cultural safety is not static or definitive, but is rather is a dynamic and flexible process. Cultural safety relies on services establishing meaningful, accountable and equitable long-term relationships with communities built on an understanding of their cultures and worldviews as well as their unique needs and strengths (Funston, 2013, p. 12-13).

Moving beyond the limited notion of cultural competency, cultural safety directs service providers to engage in a process of critical reflection. It also means developing a skilled Aboriginal and culturally safe non-Aboriginal sexual assault workforce. The Healing Foundation (no date) embrace healing programs where there is an emphasis on 'restoring, reaffirming and renewing a sense of pride in cultural identity, connection to country and participation in community' using wisdom of culture to heal and protect (no date, p. 5).

Clinical approaches

Although this literature review did not focus on treatment therapies and modalities, it is important to recognise that they are part of the service provision landscape. The Royal Commission describe therapeutic treatment as an overarching term used to *describe a range of evidence informed interventions that address the psychosocial impacts of child sexual abuse* (2017, Vol 9., p. 30). Examples of treatment modalities include counselling, psychotherapy, body therapies, therapeutic groups and psychiatric care that may include prescribed medications and are provided by qualified and accredited specialists.

The Royal Commission provide a very clear description of how difficult it can be to rely solely on therapeutic treatment for adult survivors of child sexual abuse (2017, Vol. 9). Firstly, this is because symptoms of abuse are not necessarily a disease or medical condition but rather present as symptoms arising from the trauma as

described above in the section above. Following on from this, research around how to work with trauma arising from child sexual abuse is relatively new in the space.

Practice is developing and while there is a large body of evidence about a few established treatments, there are emerging treatments that have not been systematically evaluated (Royal Commission, 2017, Vol. 9, p. 169).

The *Blueknot Practice Guidelines for Clinical Treatment of Complex Trauma* (Kezelman & Stavropolous, 2019) provide the most up to date overview of treatment approaches for survivors who have experienced trauma. The document provides 44 Practice Guidelines for clinical treatment of complex trauma to guide practice. They provide information on the most recent research and how these types of treatment modalities can be used with adult survivors in their therapeutic work. The Mental Health Coordinating Council's publication, *Reframing Responses Stage 11: Supporting Women Survivors of Child Abuse. An Information Resource Guide and Workbook for Community Managed Organisations* (Henderson & Bateman, 2010) also provides comprehensive practice guidance for working with women survivors.

Sholnsky et al. (2017) in their rapid evidence review on the availability, modality and effectiveness of psychosocial support services for child and adult victims and survivors of child sexual abuse, explored what current therapeutic service provision looked like for survivors of child sexual assault. Their study found that there was a body of 'compelling evidence' describing effective treatments, delivered in various ways that would respond to the impacts of trauma relating to child sexual abuse. For adult survivors of child sexual abuse they found that a Cognitive Behavioural Therapy (CBT) approach to treatment appears to offer the best known effectiveness for those experiencing trauma-related symptoms and internalising symptoms (such as depression and anxiety).They also found that other theoretical approaches, such as eye movement desensitisation and reprocessing therapy (EMDR) and supportive counselling may be effective but they have less evidence to support them as modalities. A number of specific individual therapeutic and group interventions have been empirically validated for adult survivors of child sexual abuse and are described in the of Grossman et al. 2009.

A developmental approach to therapy with an understanding of trauma at its core

The individual therapeutic relationship, which focuses primarily on addressing issues related to trauma, was considered important across the literature exploring responses to trauma impacts (Asche, 2014). Trauma related literature emphasised the therapeutic relationship as a key agent in survivors' recovery processes (Briere & Lanktree, 2012; Courtois & Ford, 2012; Herman, 1997) and a strong therapeutic alliance is positioned as a core component of numerous trauma-informed-practice models (Barton, Gonzalez & Tomlinson, 2012; Briere & Lanktree, 2012; Giller et al., 2006).

Empirical evidence and clinical experience supported the premise that a safe and trustworthy therapeutic alliance is essential for successful treatment (Asche, 2014). A number of studies that used qualitative interviews with adult survivors and what they saw as effective for them in their healing journey, described the actual approach of the clinician as being critical (Schachter et al., 2008; O'Brien et al., 2007). The most effective services were ones that provided a supportive, validating response through listening and providing the space for healing to begin. Overwhelmingly, in the above studies, women identified being heard and understood as the most crucial aspect of services. This is critical to think about when developing new trauma-informed service responses for survivors. Key to the effectiveness of this approach is staff training, supervision, and reflective practice (NSW Ministry of Health, 2019c).

Building trust, safety and personal autonomy in recovery

The Royal Commission describe the neurological and developmental consequences for children who have been abused, such as issues with developing healthy attachments and healthy future relationships in adult life (2017, Vol. 2). It is critical that any therapeutic treatment respond to these developmental and interpersonal impacts (2017, Vol 9). Central to literature reviewing the impacts of trauma and ways to recover from that trauma, is the concept of a phased approach to recover. This approach emphasises that emotional and physical safety is a prerequisite or starting point where the trauma impacts can be addressed (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Herman, 1997; Kepner, 2003; Kezelman & Stavropoulos, 2012; Leenarts et al., 2013; Resnick, 2012). These types of approaches aim to restore a sense of safety and control for the survivor. They are based on the broad understanding that trauma can be processed and moved on from when the survivor has adequate social and interpersonal supports and feel a sense of trust and safety (Kezelman, & Stavropoulos, 2012; van der Kolk et al., 2005). A trusting safe relationship with the survivor's therapist is key to start this process (Briere & Lanktree, 2012; Asche 2014).

A study by O'Brien et al. (2007) stressed the developmental aspect of recovery for adult survivors, highlighting that therapy was about facilitating development of 'self' and that it was critical that this happen in stages. The study stressed the importance of building a relationship with the therapist and that the therapy needed to be flexible, and survivors needed to be able to opt in and out, sometimes for short and sometimes for long periods.

Group work

Kessler, White & Nelson (2003) undertook a review of the literature examining group treatments for women who had been sexually abused as children. They concluded that from the results of the studies reviewed, group therapy for survivors of child sexual assault can be effective in reducing symptoms and enhancing everyday living functioning. They believe that although group therapy may not be entirely appropriate for all survivors it is least 'heading in the right direction' (2003, p. 1059).

Similarly for women, groups for male adult survivors have a role to play in building connection and healing in ways that individual counselling cannot do (Bruckner & Johnson, 1987; Fisher, Goodwin, & Patton 2008; Lew, 2004; O'Leary, 2009; Wilkien, 2009). A consistent theme in enhancing men's wellbeing is the importance of addressing issues of isolation in relation to men's experiences of sexual abuse. In Australia, a diverse range of models and styles of groups exist: self-help/peer groups, professional facilitated groups, psycho-educational groups, workshops, and weekend retreats. While formal evaluation and documentation of group work for men is limited, there is a growing evidence base to support the benefits of enhancing group options available to men who have experienced childhood sexual abuse (O'Leary & Gould, 2010; Foster et al., 2012)

Advocacy work

Advocacy and practical support is critical in any response to adult survivors (Royal Commission, 2017, Vol. 9; Parkerville Children and Youth Care, 2013; Sheehan, 2016). Advocates can provide support such as navigating the complex service system, making referrals, and brokering access to services such as health, housing, education and welfare services. The Royal Commission told the story of the importance of advocacy work and that advocates had helped survivors with:

- financial issues, including assisting in dealing with Centrelink,
- physical health issues, including dental and medical issues,
- education, training and employment services and opportunities and,
- legal assistance, including dealing with police, attending court and making redress and civil litigation claims (Royal Commission, 2017, Vol. 9).

Aside from the practical work, most importantly an advocate may provide the ongoing safe and supportive relationship that the survivor may need in their therapeutic healing journey (Bath, 2008; Kezelman & Stavropoulos, 2012; SAMSN, 2018). Quadara et al. (2017) also described the use of advocacy groups as beneficial in supporting survivors.

Systems advocacy, which may also be known as systems change, is a 'political process by an individual or group which aims to influence policy and resource allocation within political, economic and social systems and institutions' (National Association of Services Against Sexual Violence, 2015, p. 18). It is usually informed by the experiences of the client group and particularly seeks to bring about changes where a number of clients may have had similar negative experiences of particular systems, processes or practices (NSW Ministry of Health, 2019c) There are a range of organisations currently in Australia providing a systemic approach to advocating for adult survivors. It can also been seen to be a key component of good practice, complementing the individual work with survivors (Ibid, 2019c). Advocates for men sexually abused in childhood were focused on raising the profile of sexual abuse as a public health issue within policy discussions, in order to develop appropriate initiatives and service responses (Foster et al., 2012).

Practical Support

As part of the suite of holistic wrap around services appropriate for adult survivors, practical support is key (O'Brien et al. 2007; Royal Commission, 2017; Quadara, 2017; Foster et al.; 2012; Schachter et al., 2010). O'Leary & Gould (2010) in their work focusing on male survivors state that practical information and assistance and working to develop concrete life skills that address the impact of sexual abuse were two of the key factors that are correlated with men's enhanced wellbeing.

Herman (1997), in her ground-breaking work exploring working with the effects of trauma, advocates dealing with the most pressing practical issues for a client first. Once these practical issues are at bay, safety can be established, and the therapeutic alliance and exploratory work can begin. In O'Brien et al.'s study (2007) women presenting to services were struggling with a number of socio-economic problems such as danger of homelessness, difficulties with employment and parenting concerns. Whilst the psychotherapeutic process was important for these survivors, of equal importance was support in dealing with practicalities of housing, education, and employment, establishing a routine, and dealing with substance abuse. It was only when these were in some order that the women felt they could move on to work in therapy.

Women in this study also identified the need to deal with practical issues before therapeutic work could begin: *'You cannot work in therapy whilst constantly drug affected.'* Some participants suggested that the effect of trauma needed to be understood as a *'disability that affected every aspect of their life.'* Practical assistance included *'help and encouragement to get a regular routine happening in order to deal with the chaos, accommodation support'* and *'dealing with alcohol and drug problems first* (Obrien et al., 2007).

Peer support

Part of the work of the Royal Commission highlighted the positive outcomes when survivors were able to connect in with support groups of peer networks (2017, Vol 9.). Grealy, Farmer, Milward & McArthur (2017) in their report prepared for the Royal Commission, describe how participation in peer support groups can assist survivors to overcome feelings of isolation, guilt and betrayal by acknowledging shared experiences and maintaining involvement and connection. Quadara et al. (2017) when looking at types of services that victims found helpful, found that 74% of their population study stated peer support groups were beneficial. Particularly for men, talking with someone who is supportive and has been through a similar event can enhance wellbeing (O'Leary & Gould, 2010).

The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2006) have developed a *National Consensus Statement on Mental Health Recovery* which describes 10 fundamental components of recovery from trauma. One of these key components is peer support where the role of mutual support is a principle of recovery—the sharing of knowledge, skills and social support (Mental Health Coordinating Council, 2012). Survivors & Mates Support Network (SAMSN) is a not-for-profit organisation that provides direct support to men who have experienced CSA through its group-work programs, co-advocacy and individual planned support. Their title and philosophy highlights the importance of a peer support approach.

For men, wellbeing is enhanced not just through receiving support but through having the opportunity to support and help others (Grossman, Sorsoli, & Kia-Keating, 2006; Kia-Keating, Sorsoli, & Grossman, 2010; O'Leary, 2009). Assisting survivors to become peer leaders is an important part of some organisations' model of care. Relationships Australia Victoria identified value in developing the peer workforce and including people with lived experience of institutional child sexual abuse in the provision of advocacy and support and therapeutic treatment services. (Australian Royal Commission, 2017, Vol. 9).

Developing a trauma-informed workforce by enhancing the skills, knowledge and capacity of practitioners

A number of studies highlighted the need for a more educated and experienced trauma-informed workforce to work with adult survivors of sexual abuse (Mansfield, 2017; Quadara et al. 2017; Pullen & Hudson, 2004; Havig, 2008; Royal Commission, 2017) but also that the knowledge is supported and funded appropriately within the service system (Donohue, 2010, Reeves, 2015). NSW Health's *Case for Change* (2019) describes features of a trauma-specific service to include staff training in the impact of trauma and an application of that new knowledge in the workplace.

Quadara and Hunter (2016) outline the following components as critical for broader education and training through adopting a trauma-based orientation to program design by ensuring that:

- staff members are given specialist training in the trauma theory model;
- staff members are able to identify specific behaviours and triggers as possible outcomes of trauma;
- psycho-education on trauma is included in program design;
- staff members create a safe, predictable environment in which survivors are protected from re-traumatising experiences, and;
- survivors are provided with access to trauma and loss counselling (Quadara and Hunter, 2016, p. 26-27)

Cross-sector training

The *Establishing the Connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse* paper (Stathopoulos & Jenkinson, 2016) highlights the importance of cross sector training. They state the following to be critical for effective cross-sector working:

- both in-house (within their own organisations) as well as identifying external opportunities,
- staff consultations to understand and customise training to sector needs,
- each sector to provide training to the other sector – consultations to determine format,
- practice guidelines or factsheets,
- referral and secondary consultation information (agency names and contact details),
- practical interventions, education and information while clients are on mutual waitlists,
- intersections between alcohol and other drugs and sexual victimisation and,
- information regarding how to navigate respective service systems.

Integrated models

There is little evidence in the Australian and International literature about how adult survivors of child abuse with alcohol and other drug use issues experience treatment interventions in drug and alcohol service settings or the extent to which drug and alcohol services are addressing the mental health issues of clients with histories of child abuse in integrated ways. The ways in which the complex intersections of these issues are dealt with in practice remains under-researched and not well-understood (Sivagurunathan et al., 2019; Breckenridge, 2016). The literature review uncovered elements of how integrated practice should be approached but no clear examples of programs or models that were currently running or have been evaluated which describe specific integrated approaches to working with the three issues: childhood sexual assault, alcohol and other drug use, and mental health concerns.

NSW Health's *The Case for Change: integrated prevention and response to violence, abuse and neglect in NSW Health* (2019) and the *IPRAVAN* framework go some way in describing a move to an integrated approach to violence and trauma-impacts. Rather than describing an integrated model in detail, these documents provide overarching guidance on why an integrated approach to responding to violence and abuse is critical in the public health space. The *Case for Change* document describes how an integrated response would look in a NSW Health led service. This key Health policy document provides an overview of the critical elements of an integrated approach and define this type of response as:

Integrated service responses to violence, abuse and neglect are defined as the provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course. The degree to which service responses are integrated can be conceptualised as a continuum, ranging from service autonomy to full service integration. This continuum of service responses manifests at a system, service and practice level (NSW Ministry of Health, 2019, p. 46).

This definition incorporates concepts of:

- person-centred approaches (ACI, 2014; NSW Ministry of Health, 2018)
- seamless care (ACI, 2014; NSW Ministry of Health, 2018)
- multidisciplinary approaches (WHO, 2016a)
- trauma-informed approaches (Cocozza et al., 2005)
- addressing the holistic needs of the individual (ACI, 2014)
- taking a life-course approach (WHO, 2016a)
- a continuum of service response integration (Wilcox, 2010) and
- conceptualising service integration at multiple levels, including a system, service and practice level (WHO, 2016a; Quadara & Hunter, 2015). (As cited in NSW Ministry of Health, 2019b, p. 46).

Looking at a more direct client focused approach, SAMHSA (2000) described an integrated model approach to drug and alcohol treatment alongside therapeutic work for trauma resulting from child sexual assault. They state:

In the integrated model, which addresses dual diagnosis (i.e., substance abuse and mental health treatment), both substance abuse and childhood abuse or neglect, are treated in the same program. The provider might also serve as a mental health counsellor or address abuse issues from a psychoeducational perspective in conjunction with the substance abuse treatment. A comprehensive dual diagnosis model of this sort (labelled 'the dual recovery model') has been proposed (2013, p.6).

Other examples from the violence, abuse and neglect space that describe integrated service models which the adult survivor pilot can take learnings from include:

- The Women with Co-occurring Disorders and Violence Study (WCDVS)(Cocozza et al., 2005).
- The Meta-evaluation of collaborative interagency interventions and integrated service responses to violence against women (Breckenridge et al., 2016).
- The AOD Safer Families Program, an aspect of the ACT Government's broader Safer Families initiative, with funding provided through ACT Health, particularly their *Practice Guide: for Responding to Domestic & Family Violence in Alcohol & Other Drug Settings* (Lee, Jenner & the Alcohol, Tobacco & Other Drug Association ACT, 2017).

A Collaborative approach

The Royal Commission (2017) highlighted that:

No single service or service system has the capacity to respond to all the needs of every victim and survivor of child sexual abuse in institutions… collaboration between services and service sectors is necessary in responding to victims and survivors, particularly those with complex needs (2017, Vol. 9, p. 65).
A collaborative service sector is critically important for adult survivors to ensure that:

- coordinated assessment would remove the need for clients to retell their stories to each service provider, reducing the risk of re-traumatisation;
- there is a reduction in the fragmented nature of the service system; and
- sharing of knowledge and resources will build the capacity of the service system as a whole to meet the full range of victims' and survivors' needs (Royal Commission, 2017, Vol. 9).

NSW Health stress the importance of collaboration in their new integrated IPARVAN framework (NSW Health, 2019). In their examination of the literature around successful collaboration they state that integration developed through collaborative initiatives and models requires:

- active leadership and robust governance structures,
- shared goals and objectives between services,
- development of common frameworks and practice tools,
- formal information sharing and client consent protocols,
- 'Champions' of collaboration and integration in senior management,
- flexible and specific allocation of resources to respond to emerging priorities and,
- maintaining up-to-date evidence-based policies and procedures that underpin service delivery, and
- identifying gaps in the knowledge-base that require further research (NSW Ministry of Health, 2019b, p. 8).

Current examples of collaborative practice in the alcohol and other drug, mental health and sexual assault sectors.

Collaboration across service sectors is not a new concept. The domestic and family violence, and homelessness fields have paved the way, developing numerous collaborative initiatives, research projects, and responses to violence against women and children across very different service sectors and have had successes in new collaborative and integrated practices. For example see: Laing, Irwin, Toivonen 2010 & 2012; Laing, Heward-Belle, Toivonen, 2018; Flatau, Conroy, Clear, & Burns, (2010); Breckenridge, Rees, Valentine & Murray, 2016). Many lessons can be learnt from the work done in this space and used in the new collaborative area encompassing mental health, sexual assault and drug and alcohol services.

Although there were no specific collaborative approaches or models found in the literature review that encompassed the three sectors: sexual assault, mental health and drug and alcohol services, some relevant examples are outlined below which may guide new collaborative approaches and/or integrated models.

In 2019 the Department of Health and Human Services funded the Victorian Mental Health Interprofessional Leadership Network (VMHILN) to lead a review of theoretical underpinnings for cross-sector collaboration between mental health and AOD workforces. This project was based on the 2016 Victorian Mental Health Workforce Strategy which proposed building workforce collaboration among leaders which aimed to develop a new cross-sector leadership program that could bring together key workforce initiatives to support collaboration and test new integrated service models (Department of Health and Human Services, 2016, as cited in Minshall, 2019).

The Australian Institute of Family Studies in partnership with CASA Forum and UnitingCare ReGen (2016) developed the *Establishing the Connection Guidelines*. They are the result of an Australia's National Research Organisation for Women's Safety (ANROWS) funded project exploring the enablers and barriers of the drug and alcohol and sexual assault sectors in referring shared clients to specialist services. The guidelines were developed to build the capacity of workers in the sexual assault and alcohol and other drug (AOD) sectors in Victoria to support shared clients who experience both sexual assault trauma and substance use issues. The guidelines were prepared by The Building Partnerships Between Mental Health Services, Family Violence and Sexual Assault Services project (the 'Partnerships Project') which was initially established to improve outcomes for women with a mental illness who have experienced sexual assault and/or family violence.

Specifically, the Partnerships Project aimed to; facilitate improved relationships and service collaboration between family violence, sexual assault and specialist mental health services; improve service access and referral pathways between family violence, sexual assault and specialist mental health services; and improve service delivery outcomes for female consumers of mental health services. Local health districts developed their own local collaborative models. Examples include: S.E.A. Change, and a Collaboration between Mallee Sexual Assault Unit, Mallee Domestic Violence Services, and Northern Mallee Mental Health Service.

The Australian Housing and Urban Research Institute wrote the positioning paper on *The integration of homelessness, mental health and drug and alcohol services in Australia* (Flatau et al., 2010). Their paper aimed to increase understanding of the ways in which homelessness, mental health and drug and alcohol services can be coordinated or integrated to provide services to homeless people, the extent to which system and service integration is occurring in Australia at present and the effectiveness of various integrated service delivery responses. As part of the research study, a number of case studies were included that provided illustrations of how collaborative practices could work at the local level. These included: the work of the Haymarket Foundation, Ruah Community Services, and Homeground Services. These local studies go some way on shedding some light on the effectiveness of various integrated service delivery responses in Australia.

SECTION FOUR: A Final note on effective service provision for adult survivors of child sexual abuse

It is clear from the current literature that examines both what works, and what needs development in the area of service responses to adult survivors of childhood sexual abuse. In designing or developing any new models or frameworks, the following should be considered:

1. That the intersection of mental health, drug and alcohol and past victimisation is complex and requires a considered approach from service providers to adult survivors.

2. That a collaborative, integrated response between the varied service sectors is critical to break down the current siloed ways of working across the health, welfare and criminal justice sectors.

3. That services are trauma-informed and respond in a trauma-sensitive way to survivors of abuse, considering deeply the effects of past trauma and its current impacts.

4. That service responses are flexible and favour creating a safe and nurturing relationship with the client who guides the interactions with service providers.

5. That a range of therapies and modalities are used as part of the clinical approach to the healing journey, with a developmental approach and understanding of trauma at its core. Responses should include individual counselling, advocacy (both systemic and individual), peer support, practical support and group work among others.

6. Building safety and trust and developing personal autonomy in the client is key.

7. That the workforce is supported through education, training, peer support, supervision, and the ability to use critical reflection to develop a more appropriate and true trauma-informed response. Managerial support is critical.

8. That lessons learnt from current integrated models in the violence, abuse and neglect space, be transferred to any new pilot or way of working.

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