Relationships Australia VICTORIA

Response to the Royal Commission into Institutional Responses to Child Sexual Abuse Issues.

Paper 10 – Advocacy and Support and Therapeutic Treatment Services

30 November 2015

Relationships Australia Victoria Organisational Context

Relationships Australia Victoria (RAV) is a valued provider of family and relationship support services, delivering programs to over 19,000 people across Victoria annually. Our core expertise is in supporting individuals and families through adverse and challenging life experiences, including but not limited to; mental health issues, separation and divorce, relationship difficulties, individual support and family violence. We are a trauma-informed organisation, and this is reflected across all levels of our operations, from initial client intake and service delivery, through to senior management, governance and on the Board.

Through our 12 centres across the state, additional outreach sites and a telephone counselling service, we offer a diverse range of services including counselling, therapeutic case management, family violence services, group work and dispute resolution services. Amongst our programs, we provide therapeutic case management services to people affected by the Royal Commission into Institutional Responses to Child Sexual Abuse through our *Reclaim Support Services*, and to people affected by past forced adoption policies and practices through our *Compass Support Services*.

RAV has extensive experience and expertise in providing therapeutic services in response to trauma and the impact of childhood abuse on individuals and their adult relationships. Through *i-Connect*, our Family Mental Health Support Services in East Gippsland, and our *Reclaim* and *Compass* services delivered across the state, RAV has developed both expertise and a comprehensive understanding of the delivery of therapeutic and integrated case management models of practice. We work with individuals, families and communities that present with mental health difficulties and complex and multiple needs, especially trauma-based psychological symptoms. All of these services incorporate outreach services, community engagement components, and rely on strong inter-service partnerships.

RAV regularly shares its expertise through participation in sector reform groups, and has been involved in numerous research partnerships and in the development of improved and innovative practices. This is attested by RAV's position as a member of the Australian Institute of Family Studies (AIFS) Children's Panel, which was establish to assist community service organisations with implementation, practice and evaluation of child and family work.

RAV's Reclaim Support Services

RAV is one of 28 community-based organisations funded by the Australian Government to support the work of the Royal Commission into Institutional Responses to Child Sexual Abuse. Through its *Reclaim Support Services*, RAV provides free comprehensive support for survivors of child sexual abuse and others who engage in or are affected by the Royal Commission.

RAV's *Reclaim Support Services* has been developed using contemporary trauma theory and practice, incorporating somatic therapy (Ogden; 2006, Seigel;2010, van der Kolk; 2006, Breire; 2013, Fisher; 2012). These programs are strongly aligned with recovery-oriented principles outlined in the National Framework for Recovery-Oriented Mental Health Services. As such, principles underpinning service provision include safety, choice, collaboration, trustworthiness and empowerment. The experience of institutional sexual abuse and resultant complex trauma can be highly marginalising. Many people who contact *Reclaim Support Services* have not previously accessed support services or had negative experiences in the past, and therefore require very specific and careful engagement.

The responses in this submission are informed by our experiences of working with victims and survivors of institutional abuse, their families and significant others over the past two and half years.

Topic A: Victim and survivor needs and unmet needs

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

The model used in RAV's *Reclaim Support Services* enhances traditional case management practice by offering a therapeutic element that is trauma-informed. This **therapeutic case management model** integrates contemporary trauma theory and recovery-oriented and collaborative practice. We work with a person in context; to provide individually tailored support, therapeutic intervention, skill building, advocacy and collaborative service planning.

Our therapeutic case management approach supports people to recognise and take responsibility for their own recovery and wellbeing, and to define their own goals, wishes and aspirations. Unlike other services that focus support needs on the individual, RAV has developed a **systemic model** that has the potential to offer a therapeutic service to the client's family.

In RAV's experience as a provider of Royal Commission Support Services (RCSS), many of the victims, survivors and their families seeking support present with a range of needs beyond counselling and psychological support. This strongly affirms the use of a therapeutic case management approach which can respond to the diverse and changing needs of service users.

How potential clients would **access the service** was an important consideration in the development of *Reclaim Support Services.* When a person has experienced institutional abuse and resultant trauma, getting help can be a challenge in itself. Survivors and victims often do not disclose their abuse for many years and can struggle access support due to the ongoing psychological, social, physical and cognitive effects of trauma. The way services are located, structured and delivered can deter people with experiences of trauma. In setting up *Reclaim Support Services* we aimed to **minimise or remove as many of these barriers** as possible.

In contrast to RAV's other programs, *Reclaim Support Services* has a **central intake** point staffed by a senior clinician. This model supports people who may be fearful of service engagement, mistrustful or distressed, by providing a sensitive response from an experienced practitioner at service entry. The senior clinician also conducts the initial assessment which provides continuity for people accessing the service.

RAV's *Reclaim Support Services* use a **comprehensive psychosocial assessment** designed in a flexible way to meet the needs of the person who is seeking support. The psychosocial assessment is person first, holistic and covers a range of domains which inform a collaborative, **client-centred case plan**. The assessment assists to develop an understanding of how this person comes to present in this way, at this time. This knowledge is revised and shaped in collaboration with the client throughout period of support.

When developing a case plan we work from where the person is at, being attentive to their goals and wishes. This is about building trust and learning more about what has brought the person to the service. What do they identify as problems? What resources, capacities and strengths can they draw on? What have they tried in past to resolve problems or challenges?

Once a case plan is developed we discuss service and support options, and facilitate **warm referral** to a suitable service (internally to a RAV *Reclaim* practitioner or an external provider). How the referral process is managed depends on the needs and preferences of the individual. We actively **support transitions between services** (even internal referrals) as this is often where people 'fall through the gaps'.

Other important elements of the *Reclaim* model are s**ervice navigation and collaborative service relationships**. The contemporary health and welfare sector is complex and difficult to navigate – without the added complication of trauma. We take an active role in helping people explore their service options and negotiate access. Many *Reclaim* clients require support from a number of services, and our partnerships and relationships with external agencies are integral our work.

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

A consistent learning from our work in *Reclaim Support Services* is that our clients value **coordinated and collaborative service provision**. RAV welcomes any initiative that can help to **reduce fragmentation** in the service system.

While RAV supports the increased access to trauma treatment and psychological support through the Medicare Better Access initiative and/or Access to Allied Psychological Services (ATAPS), we have concerns how this model might limit an individual's support and undermine collaborative service provision.

The Royal Commission's recommendation to remove the Medicare session cap, expand the range of funded interventions and cover the 'gap' fee in some cases, only partially addresses the limitations of the Better Access initiative and ATAPS model. For example, Medicare-funded mental health practitioners cannot claim for activities such as attending a multi-disciplinary case conference. Any advocacy, case management or related tasks need to be dealt during the session or completed in the practitioner's own time. This represents a potential financial disincentive for practitioners to participate in collaborative case planning which may compromise the quality of support. These practitioners can also only work with groups or individuals, not couples or families; which limits the interventions available to victims, survivors and their families.

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

From RAV's experience, there are a number of factors that assist people to access support, including the following.

The **Royal Commission** is an unequivocal public acknowledgement that institutional child sexual abuse occurs; was widespread and causes significant harm to individuals, families and communities. The purpose and work of the Royal Commission is widely promoted and has raised awareness and understanding in the broader community which has helped many victims and survivors to disclose their abuse and seek support.

In RAV's experience the Royal Commission has a key part in linking people to support services. The majority of people accessing *Reclaim Support Services* do so after contact with the Royal Commission. The **warm referral pathway** between the Royal Commission and Relationships Australia's services nationally has supported this process. Many victims and survivors have spoken to us about their reluctance to seek support in the past and the significance of their abuse being believed and validated by the Royal Commission. The proposed National Redress Scheme could provide similar levels of promotion, service navigation and formal acknowledgement to sustain this facilitating factor.

Victims, survivors and their families can benefit from a **broad range of flexible and responsive services**. These include group work, peer support, whole-of-family interventions, online services

and **outreach support**. For example, outreach enables a person to receive support in an environment in which they feel safe. This can assist in establishing safety, building trust and rapport which are essential to working with people affected by abuse and trauma. Outreach provision can also ensure equitable access for people with conditions that limit their capacity to access centred-based services.

The literature on working with survivors of childhood trauma supports a range of treatment and support options in addition to individual psychological support. These include; art therapy, music therapy, sensorimotor interventions and culturally-specific programs. RAV's experience is that this is a diverse client group, with differing needs, and more work is needed to collate and disseminate evidence-informed treatment and support options.

RAV recommends that advocacy and support, and therapeutic treatment services are **diverse and multi-modal**. We support the recommendations in the Redress and Civil Litigation report for additional funding for existing specialist services, cultural awareness training and specialist training for rural and remote practitioners. Increased funding for specialist services is particularly important as organisations are often better positioned to work with people with multiple and complex needs and can offer a broader range of service responses. The proposed public register should include practitioners from a range of disciplines, delivering a diversity of service responses.

The work of the Royal Commission has highlighted the many ways institutional childhood sexual abuse can affect a person. A significant number of people accessing *Reclaim Support Services* experience long-term educational, social and economic disadvantages. Access to small amounts of **brokerage** can fund a range of activities and items to meet specific client needs. Used creatively, brokerage can have many positive benefits as purchases are tailored to the person's need, self-determined and immediate.

A significant barrier to accessing support is a **lack of awareness of trauma, its impacts and support services.** While there is increased awareness of the prevalence of childhood sexual abuse in the community, the effects of abuse on adult survivors and where to find help are less well known. The health and welfare sector lacks a common understanding of trauma and related concepts, and effective treatment approaches. To add to this, some victims and survivors cope by avoiding the topic of child sexual abuse, and as a consequence are unaware of available supports.

RAV supports strategies that increase awareness of treatment and support services among victims, survivors and their families; health and welfare professionals and the general community. Developing a common understanding of trauma and interventions amongst health and welfare professionals could support this and lead to more effective referral pathways. This work could be encompassed in the recommended National Redress Scheme, specifically the public register of practitioners. RAV suggests information about support, treatment options and redress should actively **target marginalised groups** such as people in rural and regional areas, people with disabilities, homeless populations, Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people, culturally and linguistically diverse (CALD) communities and exiting prisoners.

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

RAV recognises healthy and supportive relationships can be important to a persons' recovery from trauma. All RAV services acknowledge the centrality of relationships to people's health and wellbeing. Approximately 20% of people who have had contact with our *Reclaim Support Services* are secondary victims. These include children, partners, siblings or parents of the survivor, as well as friends and former employees of institutions where abuse has occurred.

In our experience, **secondary victims are often reluctant to engage in support** services even if they identify as having significant needs. There seems to be a strong perception among secondary victims if they accept support, they are taking resources from primary victims or survivors. This can present a barrier to engaging with support services.

RAV has seen benefits when secondary victims are able to engage with RCSS. This can create avenues for multiple sites of intervention, and amplify the strengths and capacities of the family or relationship dyad.

RAV supports strategies and recommendations that **encourage and enable secondary victims** to participate in advocacy and support, and treatment services. We would not support a separate service stream for secondary victims as it would reduce opportunities for joint and **whole-of-family interventions**, which in our experience have been beneficial.

Topic B: Diverse victims and survivors

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

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

The Department of Social Services (DSS) funds a range of RCSS to meet the diverse needs of people affected by the Royal Commission. This includes faith-based groups, Indigenous services, 24/7 telephone support services, a legal service as well as generalist providers. RAV would like to see this diversity retained in the long-term to assist victims, survivors and their families into the future.

RAV's collaborative approach extends to our formal and informal relationships with external RCSS providers and other agencies. A clear learning form the RCSS work is many of the people seeking support require a coordinated response from a number of services. Our partnership and relationships, supported by referral protocols enables us to refer people to alternative services quickly and effectively.

RAV, along with drummond street services have a formal partnership with the Victorian Aboriginal Childcare Agency (VACCA) and supplements their DSS funding to ensure the needs Indigenous people affected by the Royal Commission in Victoria are more effectively met.

RAV's *Reclaim Support Service's* largest diverse group are men. Similar to the Royal Commission client registration statistics, men comprise 60 per cent of the clients accessing *Reclaim*. Traditionally, men are much less likely to engage with welfare and support services than women, often present with brief 'window periods' in which to engage in services, and are identified in the literature as a 'hard to reach' population (FaHCSIA 2009;Tehan & McDonald 2010). We believe our therapeutic case management model, with its responsive service entry, flexible service delivery and strengths-based approach has supported men to access the service.

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

The Royal Commission's Inmate Engagement Strategy (IES) enables prisoners affected by institutional child sexual abuse to access the Commission. The IES was piloted earlier this year in Victoria and has only recently recommenced. As a consequence, RAV has had limited contact with prisoners (incarcerated or post-release). RAV's perspective is that while it is possible to work therapeutically with prisoners, it is very resource-intensive. The limited funding and increasing demand for RCSS currently preclude ongoing work with prisoners.

RAV's suggest prisoners might be better supported in the future by the following.

- Prison health, mental health and pastoral care staff having a comprehensive knowledge of advocacy and support, and therapeutic treatment services and redress options available to victims and survivors.
- Plain English information about abuse and support services for prisoners.

- Cohesive pre- and post-release case planning.
- Active linking prisoners to services post-release.
- Specialist supports streams and/or identified Medicare practitioners able to work with victims who are also perpetrators of abuse.
- Holistic psychosocial support and treatment, including support to rebuild and repair social and family connections.

Topic C: Geographic considerations

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

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

The challenges faced by rural service providers and services users who are survivors of abuse and sexual assault are well-documented (Wall & Stathopoulos 2012). *Reclaim Support Service's* rural and regional clients and practitioners raise issues such as; the lack of specialist expertise to respond to people with more complex needs, issues of privacy, dual relationships and the stigma associated with mental health problems.

The **lack of specialist support** for victims and survivors of abuse in regional and rural areas is of concern for people with complex trauma and multiple needs. The further you are from a metropolitan area, the harder it can be find or access specialist health and mental health services. People in this situation might find it difficult to find suitable support or be excluded from services. Alternatively, a victim or survivor might be receiving support from local service that is struggling to provide an effective or sustainable level of care.

The recommendation to provide psychological support and counselling to victims and survivors through the Medicare's Better Access initiative and ATAPS **potentially disadvantages rural and regional people**. Practitioners working under these schemes are not geographically evenly spread, but tend to be concentrated in more affluent parts of the metropolitan area. In RAV's experience in our *Reclaim Support Services* and forced adoption support service, *Compass* there are insufficient numbers of practitioners in some regions who skilled and willing to work with complex trauma.

RAV supports the recommendation to provide funding for rural and remote practitioners to gain training and experience in working with survivors and victims. We would encourage the Royal Commission to ensure rural and regional victims, survivors and their families have **equitable access** to quality services. RAV is concerned there will be significant service gaps in regional and rural areas if there is too greater reliance on private practitioners.

Any proposed support service models should recognise and address the potential additional costs of accessing support in regional areas, particularly travel costs. Some victim and survivor might wish (or have) to access support out of area for psychological support, to maintain their privacy.

RAV supports strategies to exploring how technology could be used to support victims, survivors and practitioners living in rural and remote areas. Online counselling support and/or virtual communities of practice could be useful adjuncts.

Topic D: Service system issues

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

From RAV's perspective the definitions provided for advocacy and support, and therapeutic treatment services are adequate and encompass many of the interventions we use in our work with people affected by the Royal Commission. We would question the separation of these two components. Our practice experience strongly supports an **integrated model** that includes elements of both. This integration does not mean providing a one-stop-shop for clients, rather it acknowledges the therapeutic value and demonstrated need for a broad range of interventions.

Early literature related to trauma-informed practice emphasised the importance of getting the balance right between the personal and the political (Herman;1992). By combining therapeutic work with case management, RAV's *Reclaim* model ensures that practitioners are able to remain equidistant to both the personal and political. RAV for example takes the concept of stabilisation, outlined in the Adults Surviving Child Abuse (ASCA) guidelines and extends the concept to include stabilisation in all areas of the client's life. This may include consideration of intra-psychic, relational and socio-political factors.

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

RAV strongly contends that service providers have a role to ensure both the needs of victim or survivor, and the needs of their family are recognised and respected in the pursuit of outcomes. It has been RAV's experience that meaningful relationships with family and friends can sustain individuals through adverse and challenging times.

There is a growing evidence base around a **whole of family approach** to service delivery which supports the recovery for an individual and prevents relapse (Carr, A.; 2000). Family relationships can provide a place for people with a history of trauma and emotional difficulties to recover and heal. A whole of family approach also provides a place to work with children, which gives consideration to the next generation and is evidenced-based (ASCA 2015).

In both its core work and in *Reclaim Support Services*, RAV extends its secondary and tertiary centre-based therapeutic work with families to collaborate with local clinical mental health and others services, in order to respond to a **gap in the sector that relates to the impact of trauma and mental health difficulties on family relationships.**

In particular these needs include the following.

- Supporting children who have a parent with a mental illness.
- Supporting parents/couples to leverage off the strength of their relationship to assist in the individual's recovery. RAV has found that relationships are a potential resource that can be harnessed, for example, to support a clinical treatment plan.

- Supporting parents/couples to repair any relationship difficulties that may be compounding emotional and mental health difficulties in addition to constraining recovery. There is much literature in regards to intimate relationships being the most salient source of both support and stress for many individuals (Walen and Lachman 2000), (Kiecolt-Glaser and Newton 2001).
- Supporting secondary victims with their individual needs. RAV works to prevent and alleviate negative features of being in an intimate relationship with someone who experiences the effects of complex trauma .

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

In RAV's experience a practitioner's qualifications and skills provide a foundation for effective practice but need other elements to ensure good quality service provision. These include individual and group supervision, regular review of client work and continuing professional development to upgrade skills and knowledge. Practitioners and organisations working in this area also need healthy work environments (buildings and equipment), sound OH&S policies and practices and a work place culture that supports a healthy work-life balance. Organisations and practitioners need to guard against vicarious trauma, burnout and compassion fatigue, but also embrace the lesser-known phenomena of compassion satisfaction which sustains many practitioners in the work.

Topic E: Evidence and promising practices

RAV strongly supports the inclusion of people with lived experience of institutional sexual child abuse in both advocacy and support, and therapeutic treatment services. Research literature and practice-based evidence from the mental health sector shows the value of developing a peer workforce, the inclusion of 'experts by experience' at all levels of organisations and co-design of programs and services.

RAV suggests **early intervention whole of family work** is a promising intervention in the complex trauma field. Research now shows that impacts of even early severe trauma can be resolved, and its negative intergenerational effects can be intercepted, with comprehensive assessment and planned intervention in the context of excellent, purposeful caregiving relationships.

RAV's work with children and families affected by complex trauma is informed by Cook et al (2003) in their White Paper on Complex Trauma in Children and Adolescents. The authors stipulate that interventions for children who have experienced complex trauma must be phase-based and address specific domains:

- safety in one's environment
- skills development in emotion regulation and interpersonal functioning
- meaning making about past traumatic events
- enhancing resiliency and integration into social networks.

Case studies

Case Study 1

David is a 57 year old divorced father of two adult children who lives alone in public housing. He has not worked since the breakdown of his marriage seven years ago and has little family or social contact. David was referred to *Reclaim* after registering with the Royal Commission into Institutional Responses to Child Sexual Abuse. He is a survivor of clergy abuse at high school. During the assessment interview David talked about how the abuse has affected his life. For many years he "put it all in a box, and everything was fine". David was a high achiever in his professional life and described himself a workaholic. The breakdown of his relationship triggered depression, nightmares related the abuse and panic attacks. He started drinking to excess to manage the symptoms. As result he has "lost his marriage, home and children". In hindsight he can see he was more affected by the abuse than he previously believed. David expressed a deep sense of shame and guilt about his current circumstances and "failure" as a husband and father. He sought support through the church's professional standards office a number of years ago. He described the process as "more damaging the abuse". He received a small amount of redress, which he used to pay for his daughter's school fees.

During the development of his case plan, David's priorities were to improve his sleep patterns and prepare for his private session with the Royal Commission. The *Reclaim* practitioner talked with David about what would support his goals. From this conversation, they added two more goals to improve his social connections and better manage his health.

David started ongoing work with a female *Reclaim* practitioner at the Relationships Australia Victoria (RAV) office in his area. He expressed preference for a female practitioner as he found difficult to trust men. Over the next six months David met with the *Reclaim* practitioner. It took several months for him to build trust and his attendance was erratic. The practitioner's persistent engagement and focus on his needs and goals ensured David felt heard and respected.
David and his *Reclaim* practitioner worked to find him a new female General Practitioner (GP) who had a better understanding of mental health and trauma. David and his GP, supported by the *Reclaim* practitioner developed sleep hygiene strategies to improve his sleep patterns. The *Reclaim* practitioner linked him to a weekend retreat for male survivors run by a sexual assault service. From this he was able to draft a written account for his private session. The *Reclaim* practitioner assisted with the final draft and supported him at the private session. At the retreat David formed a friendship with another survivor, and they met regularly for coffee. From this positive connection, David started to explore how he might rebuild his relationship with his daughters and possibly return to work or study.

Case Study 2

Mary is a 52 year old woman who presented to RAV *Reclaim* program with a mixture of anxiety and depressive symptoms often precipitated by normal everyday stressors, on a background of sexual abuse perpetrated by a priest in her community from the age of 8 to 12 years. Mary, who lived with her husband of 30 years, Bill, and two adult children aged 20 and 22, reported high levels of conflict and verbal abuse between Bill and their eldest daughter, Kate, and a deteriorating relationship between herself and Bill.

The referral had been precipitated by Kate's recent suicidal ideation and a deterioration in attendance to her university course. Kate was described as experiencing many rages in the house and often kicked in doors and put holes in the wall.

Mary stated that she had attended "lots of trauma counselling" over the years, and felt that she understood her experience of trauma and sexual abuse, but that what she really wanted was for the "yelling in her family to stop" and to not feel as depressed and panicked all the time. Mary stated that the panic was so bad that she had become scared of travelling and had not been away for five years.

Mary stated that she did not feel that her husband understood her past experience of sexual abuse and was very resentful in regards to the lack of travel and holidays in their life.

By integrating the current and past relevant information provided by the family, the Clinical Care Coordinator prioritised Mary and her family's stated needs and goals and developed the followed plan:

- Mary attended six sessions of individual focused psychological strategies in order to manage her panic and depressive symptoms more effectively. Mary was assisted to accept 'normal everyday' feelings such as disappointment, frustration, worry and anger and to differentiate these feelings from past traumatic feelings. Mary was also assisted to manage feelings of panic and was actively assisted to plan small steps towards going on a holiday with Bill.
- Mary and Bill attended couple/parent work in order to find ways to decrease the conflict in the house and to assist Mary and Bill to explore the impact the past traumatic was having on their relationship and their whole family. In this, Bill needed to take responsibility for his anger and consider the impact of his own history of trauma. The counsellor also assisted Mary and Bill with the escalating violence being perpetrated by Kate by encouraging parenting practices that did not support violence.
- Kate was referred to an adult mental health service for a full assessment, who subsequently referred Kate back to RAV for individual work. Kate used her individual work well. Kate was provided with psycho-educational work in regards to living with intergenerational trauma, was assisted to take responsibility for her own aggressive behaviour, and supported to find other ways to manage anger and frustration. Kate was assisted to place better boundaries around herself in respect to her family relationships, in order to enjoy her parents, whilst remaining independent and safe.
- The individuals in the family were subsequently able to stabilise their more acute symptoms allowing for all four members to attend family therapy with the family's stated aim to yell less and try to understand each other more. Mary, Bill, Kate and her brother, Sam attended four sessions of family work which assisted the family to repair and move towards safer interactions.
- Mary was able to use the skills she had learnt in respect to panic and anxiety and slowly moved towards a weekend away with Bill. Kate expressed a desire to move out of home and her counsellor assisted her to be linked into support on campus to student housing. All family members stated that they were in a habit of "firing up pretty quickly" however, all were committed to trying to practice de-escalating, soothing themselves with strong emotions, and repairing if things did not go as planned.