Limiting Choices

Critical Analysis of Proposed 'Hub' Model

Addendum to
"The Right to Choose"

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Preface

Twenty (20) community-based sexual assault services are funded (or partially funded) by Queensland Health. These services have played a major role in responding to the needs of people who have been sexually assaulted in Queensland for many years.

In 2008, Queensland Health appointed KPMG to review the existing adult sexual assault service system in Queensland. Their report was published in mid 2009.

Non-government services agreed that the KPMG report did not take sufficient account of the evidence about the nature of sexual violence and the needs of people who have been sexually assaulted. The report's recommendations are inconsistent with emerging national policy directions and existing Queensland Government commitments and obligations. As a result, the proposed model has significant shortcomings.

Following release of the KPMG report, Queensland Health appointed the Spall Watters Group to gather stakeholder feedback on the report and ideas for moving forward. It was widely felt that the Spall Watters Group report did not adequately reflect the concerns raised by non-government sexual assault services during the follow-up consultation process. It also appears that there was no Indigenous input to this process. A group of community-based services therefore met, and decided to commission its own study into the needs of people who have been sexually assaulted, and the service delivery systems and models of service required to meet these needs.

In July 2010, Queensland sexual assault services jointly published a proposal for an effective and efficient service delivery system: ***A Right To Choose:*** **Enhancing Best Practice in Responding to Sexual Assault in Queensland**. It was not possible within the constraints of that document, to provide a detailed analysis of 'hub' model of sexual assault service delivery, which proposed a single entry point to sexual assault services throughout Queensland.

This addendum to the ***The Right To Choose*** report should be read in conjunction with the main report. It is a compilation of concerns about the proposed model, raised by community-based sexual assault services in Queensland.

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9/4/10

To Whom It May Concern

My name is Trudie ... and I am writing this letter in order to portray my support in keeping Phoenix House as a separate identity from a hospital environment and allow them to continue to do their proffessional, supportive, tireless work in which they help rebuild and nurture the lives of sexually, emotionally, physically abused people of past and present of all ages and races.

I do myself feel I can comment from life experience and not just a text book as I am a woman has suffered the abuse being molested as a child. I grew up in Brisbane and when sort help for myself got the best available to me in Brisbane from the leading hospitals (Prince Charles, RBWH). I did come out of the clinical hospital system perceived as being fine even though I knew I was not. The hospital did do their job yes to a text book degree, and yes with professionalism, but Phoenix House is much more than a clinical place.

If I can once again go back to life experience; when as a person you are abused sexually, emotionally and physically, you yourself become clinical and shut down and shut off in so many ways in order to survive; and as a survivor I can honestly say you do not and will not trust or open up to or start to get a life back in a clinical hospital environment; because of the fact the perpetrator in a way has emotionally put you in a baron emotionless clinical-like life. A human being needs to feel safe and not just a number after a criminal hideous act like this abuse has been bestowed upon them and unfortunately a hospital environment has the effect of you being a number whereas Phoenix House offers so much more. The women who work at Phoenix House are proffessional, dedicated, devoted and caring above what their work ethics asks of them they give 100% and then more: they also offer animal therapy in the way of canine and equine which is studied to be very beneficial for trauma. (Another benefit which hospitals don't have.)

Where I am today after being through the hospital clinical system and now having sort help through Phoenix House there is no comparison.

I honestly believe as a survivor of this trauma Phoenix House does an important job in supporting our communities damaged souls of babies, children, teenagers and adults and leading through to come out the other side healthier people. Hospital clinical environments should be for the perpetrators not the abused.

Text of a letter from Trudie (reproduced verbatim with her permission, with surname and address removed), a service user from Phoenix House, Bundaberg:

The KPMG report proposes that a single model of service be applied across Queensland. The 'hub' model would be designed to offer the same services to anyone who has been sexually assaulted. Non-government service provision would be de-funded[1], and all services would be provided by Queensland Health Districts, through single consistent entry points located (probably in hospitals) throughout Queensland.

Reduced access to a complete service

The KPMG report assumes that a single *consistent* entry point (probably in a hospital) would increase the likelihood that people who have experienced sexual assault will access a more complete service[2]. All the available evidence suggests that the opposite would occur.

Entry points are not just physical locations. They are a point of communication that link people who have been sexually assaulted to the information and responses they require across all relevant human services. Non-government services are very visible within the community. Relocation of services for people who have experienced sexual assault is likely to result in reduced visibility.

Access to crisis support in the 72 hours following sexual assault is important. Intensive support, including counselling, can help service users *recover mastery over their lives*[3]. However, primarily or exclusively relying on a crisis response to sexual assault is unlikely to address the needs of the majority of people who have been sexually assaulted throughout Queensland because:

1. Most people who have been sexually assaulted do not seek professional help immediately.
2. Whilst crisis support can improve the prognosis for recovery and quality of life of service users, many people who have been sexually assaulted are re-traumatised at some time in the future.

The ABS *Women's Safety Survey* in 1996 estimated that only 9% of women who had experienced sexual assault since the age of 15 years had seen a doctor[4]. The data are not specific about the setting in which the doctor was consulted. Hospital separations data, available from the Australian Institute of Health and Welfare (AIHW), record hospital separations of admitted patients whose admission is attributed to sexual assault as an external cause of injury. For the three years 1998-99 to 2000-01, the numbers of separations for female patients across Australia were steady at around 230 per year, with a small increase to 310 in 2001-02[5].

Anecdotal evidence suggests that very few women present for any form of service in the first 72 hours following sexual assault. Most are traumatised and do not begin to think about seeking professional help. Forthcoming information from a Queensland Health survey should quantify this[6]. Between January and June 2009, Queensland Health asked non-government sexual assault services to identify the number of people they saw within the first 72 hours, within 2 weeks and after 2 weeks. Informal feedback from a number of services suggests that they rarely see anyone in the first 72 hours, 20% - 30% of women seek help within 2 weeks of an assault, and 70% - 80% present more than 2 weeks following an assault.

Reliance on forensic and follow up medical care and a few sessions of solution-focused intervention over a 6 week period fails to recognise the full impact of sexual assault. An on-site appointment based support system would not address the needs of the majority of people who have been sexually assaulted. At a therapeutic level, individualised counselling will not meet the counselling needs of many service users.

The criminal justice system also functions as a key barrier to reporting sexual assault. Women repeatedly report finding the legal system difficult and often undermining of their experience of sexual violence, as the following comments from participants in a recent BRISSC survey[7] with 500 respondents demonstrate:

> *I found reporting my experience with domestic violence and sexual abuse to the police to be very negative. I felt like they didn't believe me. There was no follow up. I felt vulnerable and not taken seriously. It was a bad, damaging experience. I think they didn't believe me because it was my husband. It occurs more often than people may think.*

Please be aware and help. Support the victims.

Professionals in court need to respect personal space. Don't intimidate children. Don't make a child feel that they need to provide the outcome, e.g. "Do you want your father to go to jail?"

It happens so much and it goes unreported. Women and girls are not supported enough by the courts without having their name dragged through mud and made to feel like it is there fault. Court system seems to currently protect the persecutor not the survivor.

I believe that acts of sexual violence should carry stronger penalties, which would require re-education of judges handing down these sentences.

KPMG proposes 7 strategies which represent *opportunities to strengthen service provision for adult victims of sexual assault*[8]. All of these strategies focused on service provision by doctors, nurses, counsellors or police - all working within the confines of their respective roles. None of these strategies addresses needs beyond the first few weeks following an assault. None of these strategies recognise that different individuals and groups feel safe in different types of service environments and benefit from different service approaches. None of these strategies propose means by which the criminal justice system could better respond to the needs of victims of sexual violence. Whilst a single streamlined system might be easier to design and manage, it is difficult to see how these strategies can benefit the vast majority of people who have experienced sexual assault.

The KPMG report identifies forensic and medical examinations, counselling and support as the *core functions* required by people who have been sexually assaulted. Establishment of pathways to police and justice responses is treated as a high priority.[9] Whilst *stronger partnerships between police, health and justice responses*[10] might improve the experience of the small percentage of victims who report their assault within a short period of time[11], it is difficult to see how most people who have been sexually assaulted would benefit from this. A forensically-driven approach may mean that women who are not willing to submit to a forensic examination are at risk of receiving no service at all.

KPMG also fails to address:

- How hubs would address the needs of victims facing sexual violence outside the narrow definitions of the criminal code.
- How hubs would be made safe for women service users.
- How hubs would address existing barriers to using hospital-based services and attract a larger proportion of service users than hospital-based services have in the past.
- How the hubs would address current barriers to accessing support, including - fear of disbelief by the police and legal system; lack of control over the post-reporting process; cultural insensitivity and failure to address cultural/language differences; failure to provide information and options; exclusion of the victim from decision-making.
- How the expertise of community-based services would be used to inform design of these hubs.
- How the hubs would address victim perceptions - that there is no point in going to the police, because they don't have a witness to back up their rape allegation; there is no point in going to a hospital, because all their medical issues can be treated by a local GP.

It is difficult to see how these hubs will be able to work effectively with the majority of people who currently do not report a sexual assault. In particular, it is difficult to see how hubs will be able to meet the needs of those seeking support for past sexual violence.

Prescriptive practice approaches reduce service options

KPMG report proposes a *common set of practice principles*[12]. The capacity of services to meet the multi-faceted needs of victims/survivors would be severely limited if services were restricted to working within these. Translated in the context of the Report's concept of *best practice* in service delivery these practice principles imply:

- Service users could control the pace of intervention, but would have little say in the type of support available.
- Cognitive behavioural therapy (CBT) would be a central intervention tool.
- Counselling would be delivered by generically-trained professionals.
- Groups *that face greater barriers to using services* would have no choice except to access hospital-based services.
- Service users might be pressured to undergo forensic examination as soon as possible, to optimise collection of evidence.
- Service users' privacy might be compromised by the practical constraints of a hospital environment.
- Service users' sense of safety might be compromised by the on-site presence of police.
- Any follow up care would be limited to mainstream medical and psychological services.
- All service providers would be required to function within closely defined roles.
- No services would be available to meet needs which fall outside individualised forensic, medical and psychological services.

The current Queensland Health Interagency Guidelines encourage clear and comprehensive information provision, delivered in a non-judgmental manner, which enables service users to make free and informed choices about all processes and options. Currently, the customised support provided by non-government services offers an alternative to medically-based counselling approaches. Introduction of more standardised approaches will provide less capacity for client-driven models of service and flexible, responsive, service delivery. For economically disadvantaged women (the majority of women in groups which face a high incidence of sexual assault) who are dependent on free services, this counsellor-determined approach would remove any choice of service.

Evidence suggests that CBT is not the best overarching model for working with sexual violence. CBT is particularly inappropriate for use with Indigenous women and other socially vulnerable groups. It is important that *Interventions for survivors and recent victims of sexual assault need (are) informed by trauma theory and an understanding of approaches to addressing trauma*[13]. There is an emerging body of evidence that the key determinants of effective counselling and therapy are factors other than the therapeutic model. These include the person's support system, their sense of rapport with the counsellor and their power in the counselling process[14].

There is no guarantee that generically-trained professionals, will have any education or training in the social and cultural context of sexual assault or specialised sexual assault (or trauma) counselling:

> Dr Jenny Gilmore, a Social Worker and Lecturer at University of Queensland lectured in a youth work subject for social work students. In 2003 she prepared a class for 3rd and 4th Year social work students on *Young People and Childhood Sexual Assault*. The workshop had been prepared on the assumption that students would have developed some understanding of sexual assault issues throughout the course. When she went to deliver the workshop, she asked students what content related to childhood sexual assault had been covered throughout the course to date. Every single third and fourth year student said that there had never been a single mention of sexual assault throughout the entire degree. Half the group members were 4th Year students close to completing the degree.

There is also strong evidence that most members of particularly disadvantaged populations (including Indigenous women, NESB women,

people from rural/remote communities, LGBT[15] people, criminalised women and women with disabilities) would be less willing to access hospital-based than community-based services. Being limited to hospital-based services is inconsistent with the current Interagency Guidelines which require service provision which is sensitive to *language, culture, age, disability, gender, sexuality and location.*

Forensic examination is irrelevant unless women pursue charges. Further, women can decide to report a sexual assault at any time in their life. The focus on providing forensic services in the KPMG report increases the risk of service users being pressured to undergo forensic examination as soon as possible, to optimise collection of evidence. There is already pressure on sexual assault workers to limit their support to women who are intending to press charges, to avoid contamination of evidence. There is already an inclination for a doctor, rather than a social worker, to record the woman's story (despite their lesser training in counselling), in order to preserve their status as *the expert witness.*

Within the hub model, service users' privacy may be compromised by either their need to state their *medical* problem to untrained emergency department reception staff and/or, enter an area of the hospital clearly marked *sexual assault*. These threats to women's confidentiality are of particular concern in rural and remote areas, and are inconsistent with the Interagency Guidelines.

Many members of particularly vulnerable groups have had adverse experiences with authorities (either in Australia or other countries). Police presence in the 'hub' environment would serve to further preclude women with negative experience of police, particularly women with mental health issues, criminalised women and Indigenous women. On-site presence of police places service users' sense of safety at risk, and has the potential to re-traumatise women attending the service for longer term support.

According to the KPMG model, follow up care is limited to medical and psychological issues. The report proposes an appointment based system, and service provision driven by assessment and intervention decisions made by professionals. This is inconsistent with requirements of the current Interagency Guidelines which require that service providers respect, support and encourage service users' personal control at every stage of the process. An *expert driven* approach puts women in a passive role which actively undermines their potential self-empowerment, development of resilience and recovery. A diagnostic focus has limited capacity to respond to individual women's unique characteristics and individual circumstances. Women who have experienced multiple incidents of sexual assault, or who are facing issues such as mental health or substance abuse issues as a direct consequences of their sexual assault, are at risk of being told: *You can't talk about that here … you can only talk about <u>this</u> incident.*

Further, KPMG does not propose provision of services to address critical safety and physical needs (eg. housing and crisis income support) as currently required by the Interagency Guidelines.

A forensic focus fails to address the needs of most victims of sexual assault

Forensic services are currently relevant to less than 9% of people who have been sexually assaulted in the preceding 72 hours.

The current reporting and forensic process reflects the needs of the criminal justice system, rather than the needs of victims of crime. The requirements of *objective* forensic examination and maintenance of continuity of evidence, inevitably function to undermine key needs of people who have been sexually assaulted.

When victims initially present at a police station, police are required to be in attendance from the time of initial reporting until a statement is taken. With the intervening forensic examination taking 1-2 hours, and a statement often taking several hours to prepare, this means that traumatised people cannot access supportive services (or, on occasion, family or friends) for several hours. For women from many parts of rural/remote Queensland, this can extend into a 24 hour process - by the time the woman is driven, often by male police officers, from her community or town to a rural or regional hospital. The police are required to take an objective approach, and cannot provide evidence that the woman is being believed. This can be particularly damaging, given that most women who have been sexually assaulted feel unsafe in the presence of men, particularly men in positions of power.

Forensic Medical Officers (FMO), General Medical Officers (GMO) or Forensic Nurses undertaking forensic examination are required to collect data in an unbiased fashion. This precludes any opportunity to demonstrate to the victim that they are believed, or focus on their perceptions and emotions. Further, particularly in rural areas, women often do not have the option of examination by a female doctor or nurse. Examination by a male doctor can be particularly traumatic for victims of sexual assault. The common requirement for women to re-tell their story 3 or 4 times to different medical and police personnel, can also re-traumatise women.

Difficulties in getting a conviction for a sexual assault requires police and medical personnel to ensure a seamless process to maintain continuity of evidence. In particular, defense lawyers have challenged the viability of evidence, once women have received emotional support. A forensically-focused system encourages police and medical personnel to pressure women to passively submit to a long and emotionally and physically invasive process (which many describe as being re-raped) prior to receiving any other form of support.

Once a woman agrees to submit to the forensic process, she generally has little control over the process. Forensic imperatives take precedence over the woman's needs. Police have been known, particularly when the alleged offender is identified by the victim, to pressure women to proceed with the legal and forensic process, without providing sufficient information to make an informed choice. In particular, women report having not been advised that they can report the offence at any time, and that a forensic examination is not essential to filing charges. Women report not having been advised of justice-driven (as distinct from legally-driven) alternatives such as Project ARO (Alternate Reporting Options), previously known as Project USA (Unreported Sexual Assault).

An exclusively medical framework increases the risk of inappropriate treatment

The Western medical model focuses on addressing presenting problems, rather than underlying issues. It is concerned with addressing symptoms, rather than causes. It is not concerned with looking at a person in their whole-of-life context. It has limited capacity to respond to a diversity of needs, or address specific needs such as engaging an appropriate interpreter for NESB women, or arranging safe housing when someone has been sexually assaulted by a family member. Doctors and nurses are primarily trained to respond to physical, rather than emotional, needs:

> *Primary health care providers have been trained to develop expertise in diagnosis and treatment of ill health and to act as authority figures in relation to their clients. As such they become accustomed to devising treatment plans, giving advice and expecting clients to adhere to those plans and advice ... Indeed it is likely to be highly counterproductive with sexual violence because it mimics the controlling behaviour of the perpetrator and reinforces the woman's sense of powerlessness and lack of agency. Health care workers must strive to be as unlike the perpetrator as possible in all their interactions with victimised women. A non-directive, woman-centred approach is indicated.*
>
> (Astbury 2006, p 20)

Emergency departments are, by definition, driven by the imperatives of urgency, as defined by medical practitioners:

> *People who come with a sexual assault situation are not given the space. A busy emergency department is not the place. A person waits in a room for isolation purposes. It's just not fair.*
> (Nurse in the Emergency Department of a Brisbane hospital)
>
> *… I've got real patients to see …*
> (One doctor's response to a woman's emotional distress, immediately following a sexual assault, observed by a sexual assault worker)

Immediately following sexual assault, women are often concerned about the possibility of Sexually Transmitted Infections (including HIV) and pregnancy prevention. However, except in the case of traumatic physical injury, women who have been sexually assaulted rarely express any other medical needs. On occasion, these medical needs of women have been overlooked in the forensic medical process.

In general, the medical model is concerned with fixing problems quickly. Hospitals are concerned with managing high turnover. The hospital-based medical and mental health systems have little history of follow up of people with complex needs. Staff within the Queensland Health medical system are generally required to work within narrow job descriptions, which rarely allow them to undertake follow up, even if they are aware of the need. The role restrictions within the hierarchy of hospitals results in a siloed approach to service provision, where professionals rarely collaborate, and each fulfils their prescribed role then passes patients to the next professional. Whilst General Practitioners (GP) are sometimes an exception to these norms, few have specialist sexual assault expertise.

Medically-based models encourage the counsellor to take an *objective*, de-personalised approach and to rely on technique rather than relationship to address *the woman's* problem. Whilst this greater detachment can allow for some insight, it most commonly fails to address women's specific sexual assault counselling needs. It can be damaging to a woman who has been sexually assaulted, when her emotional needs do not *fit into a box*, are therefore not addressed, and are later misdiagnosed as a mental health issue.

Hospitals or *institutional* venues are adversely suited to the needs of women who have been sexually assaulted. Such environments reinforce the feeling of helplessness generated by sexual assault:

> *… Any clinical examination procedure that places women in a helpless, powerless or humiliation position where it is impossible for them to exercise control or wellbeing and/or physical integrity and dignity, will serve as strong reminders of the violence endured outside the consulting room.* (Astbury 2006, p 20)

Where experts (generally health professionals) are seen to be in control, the powerlessness of the survivor is inevitably compounded. Medically-based counselling is driven by a *power-over* approach - where the counsellor is the *expert*:

> *When I see my psychologist, I'm the one who is sick and the psychologist is the expert. In group I realised the other women were experts on had happened to them and so I must be too.*
>
> *Getting together with other women and sharing stories has made me finally feel like I'm not the only one in the world. We are NOT 'mad' we are survivors! This is invaluable.*
>
> (2008 & 2009 participants in a 10 week support program conducted by BRISSC)

Medically-driven counselling requires the *client* to submit to a counsellor driven and determined process. This undermines women's capacity to make their own choices and decisions, take power and control over their lives and develop the resilience required to address the symptoms of sexual assault:

> *It's important to look at the role of psychiatry in invalidating women who have experienced trauma.* (BRISSC online survey participant)

The mental health system has limited capacity to respond to the consequences of sexual assault. The following scenario, describes the response of the mental health system to the needs of a woman supported by BRISSC (in February 2009):

> A woman experienced incest over a 10 year period from 5 - 15 years of age. She left home/father at 15 and 'found' a new home with a violent man and his `gang' who currently terrorise, rape and force her into prostitution, drugs and pornographic trade. She self harms and attempts drug overdoses on a weekly basis, and is held captive, unable to leave the violence for fear of reprisal and potential death. She expects that the mental health system will help her to stop thinking about suicide and attempting drug overdoses.
>
> The system offers her a 'safe' place for a few nights and prescribes medication. The mental health workers diagnose that she is not mentally ill – and assert that leaving the DV would be her best medicine. The mental health system doctors have not offered counselling/referral to work through the emotional and physical barriers of leaving a community of organised crime and violence, and have too few strategies to address the effects of her coping strategies. The mental health system periodically offers her a

temporary bed for a night over the weekend or a few days, offers to prescribe her medication and follows-up on how she is taking her medication.

People working within the medical system generally assume that women who have been sexually assaulted will simply make the adjustment and *get over it.* Conventional therapeutic approaches not specifically designed for trauma work are often used with little or no (positive) effect. Symptoms resulting from unresolved emotions arising from sexual assault are frequently given mental health labels. Medication is used as a primary tool to address *the woman's problem.* Consequently, women who have been sexually assaulted are at risk of perceiving themselves as the problem.

> *… being labeled, medicated and having my emotions numbed down did not help me work through or learn to cope with my distressing thoughts and feelings.*
> (Service user, age 55, Central Queensland, after accessing mental health services for symptoms resulting from sexual assault.)

The distressed behaviour that commonly follows a sexual assault is a normal, healthy, reasonable response to trauma. Medicalisation of these responses shifts responsibility for the assault from the perpetrator and the wider society, to the individual woman. Medical staff generally have little training in addressing normal responses to emotional trauma, and tend to blame women for their post-traumatic behaviour. Commonly, medical personnel act in a way that is directly contra-indicated in the case of trauma - that is, take away the person's power through treating their behaviour as a mental health problem, or a security risk.

On occasion, medical personnel recognise that they do not have the required competencies to address the needs of women who have been sexually assaulted. Many non-government services receive large numbers of referrals from Queensland Health services, including sexual assault services. Despite the fact that non-government sexual assault services are generally perceived as low in the professional hierarchy, these services consistently report being asked to provide specialist training for medical personnel and to accept referral of women with particularly complex inter-related needs:

> *We're getting more and more referral from private psychologists. As soon as women say they're been sexually abused, the psych will say 'I think you need to go to a specialist service'.*
> (Sexual Assault Counsellor, SE Qld)

Women with pre-existing mental health needs, or a past mental health diagnosis, are particularly vulnerable within the medical system. They are at even greater risk of having their experience of sexual assault denied. Escalation of a pre-existing mental health need, or self-harming or suicidal behaviours, are rarely treated as symptoms of sexual assault:

> *CASV has undertaken a great deal of research on the links between survivors of sexual violence and mental illness. Unfortunately, many people who present to mental health services have underlying issues of post-traumatic stress disorder and other conditions arising from cases of sexual violence. In some cases these underlying conditions are identified and in other cases the underlying causes remain unaddressed.*
>
> *These circumstances create a risk of survivors of sexual violence cycling through mental health services that may not necessarily address the nub of their problem. I hope that this matter is one that can be given the significant consideration it deserves by clinicians and policy makers within Queensland Health. It is an important opportunity to prevent mental illness, keep people out of hospitals and provide a quality of life for people living with mental illness.*
> (Speech by Evan Moorhead, member for Waterford, Hansard, Thursday 11 March 2010)

The mental health system appears unable to deal with a dual diagnosis:

> *Our mental health service doesn't work for people with mental health issues … so how can it possibly work for women who've been sexually assaulted or have other issues going on?*
> (Sexual Assault Worker, Central Queensland)

> *I got nowhere at mental health, they did not understand, but you understand.*
> (Non-government service user, Central Queensland)

Conversely, non-government sexual assault services report experiencing great difficulty

referring women with extreme mental health symptoms, to Queensland Health services.

Reducing the number of people accessing services

Women who have experienced sexual assault - either recently or in the past - do not generally see themselves as *sick*. Sexual assault is not generally perceived as a *medical* problem.

The KPMG report claims that *anecdotally, victims of recent assault appear to be most likely to seek assistance from a hospital emergency room or from the police*[16]. This is inconsistent with both the ABS[17] and AIHW[18] data which indicates that a very small percentage of victims present at emergency departments or police stations.

Most women agree that they would not choose to access **ongoing support services** in a hospital setting. As one woman said:

> *It was cold, I felt trapped, was just a number, being in a small area I felt trapped just like when I was being raped.* (Non-government service user, Central Queensland)

All 4 women who saw the same counsellor, at the same service, on the same day[19] at Phoenix House, Bundaberg commented on their willingness to use hospital-based services for ongoing support:

> *Transferring the adult counselling service to the hospital would be a bad thing. Pretty devastating. There would be no equine or canine assisted therapy. No, don't take the service away from Phoenix House. I probably wouldn't be here if it wasn't for Phoenix House. I don't think the hospital would be a place I would go to, it's too impersonal and formal for me to feel safe to talk about sexual abuse or any other sort of abuse*. (Kym)

> *I don't think that's a good idea. I would rather keep coming here to Phoenix House. I don't feel comfortable at the hospital.* (Kirsty)

> *Going to the hospital would lose the personalized empathic approach and support. At the hospital one is classed as a number. I would really object to having to go to the hospital for sexual abuse counselling. I totally disagree with this kind of service going to the hospital. I think it would be too impersonal. We need to feel comfortable with who we speak to about a topic as sensitive as sexual abuse. This is a kind of situation where we had no choice (about being abused), no control about our lives and now they (the government)* ***are trying to take it (control) away from us again!!!*** (Leah)

> *That would be awful if they took the adult counselling service away. The hospital would be too clinical, too impersonal. People don't open up about sexual abuse in such an environment. We wouldn't get the opportunity to attend equine therapy which really works. That would be wicked. I don't know where I would be without Phoenix House.* (Emma)

The consensus amongst these women is clear. These sentiments were universally supported by formal and informal feedback of service users from many different non-government sexual assault services. An online survey conducted by BRISSC involving over 500 respondents found that *positive social support* was the most important determinant of women dealing with sexual assault[20]. This key attribute of successful treatment of sexual assault is inconsistent with a medically-driven response to sexual assault.

Disadvantaged groups of women are particularly unlikely to present at a hospital based service for either crisis or ongoing support. Many women in rural and remote Queensland do not have easy access to a hospital. Indigenous women, immigrant and refugee women, criminalised women, women with intellectual disabilities and young women are particularly cautious about services provided in an institutional setting.

These perceptions are supported by the conclusions of the National Council:

> *A one-size response does not fit all victims and their children. Service systems are currently inadequate in supporting women in all their diversity. They are insufficiently integrated to provide a seamless and coherent service that addresses the multiple impacts violence has on a woman and her children's health, housing, financial,*

employment, schooling, family and social support needs.

(National Council to Reduce Violence Against Women and Their Children, 2009[21])

Excluding women from disadvantaged groups

The hub concept is particularly inappropriate for women from disadvantaged populations. A government-style facility would be unlikely to suit the range of practice models required to address the particular needs of different population groups of women - including informal peer support, group work, whole-of-family work and immediately accessible childcare during sessions. As one worker said:

> *'One Size Fits All' simply won't work. The dress may 'fit' everyone, but it doesn't look good on anyone!* (Specialist sexual assault counsellor)

Rural and remote community organisations were particularly concerned about the potential impact of the KPMG model, on women who have been sexually assaulted from remote areas. The model greatly increases the risk of reduced access to services for women in rural and remote areas some distance from the nearest major hospital. Tablelands Sexual Assault Service imagined the scenario for woman from Mt Garnett, if the 'hub' were located in Cairns:

> Woman reports a rape at Mt Garnett. Is driven to Cairns for Forensics. Woman is in a police car with a male police officer (we have very few female police officers here) for 3 hours on roads that are poorly maintained, (we have areas that many locals will not travel because they become car sick), and then for another 3 hours following the exam and interview. This is a big ask of a woman who has just been raped, and Mt Garnett is not the town at greatest distance from Cairns. We did a quick survey of our current clients and they all felt that having to travel to Cairns would be a deterrent to carrying through with reporting rape.

Regional, rural and remote services foresee the risk of centralisation of services to regional cities occurring over time. Services are particularly concerned about the diminished choice of services and women's access to services to address past sexual assault.

Many foresee sexual assault services functioning in a similar way to mental health services which have failed to meet the needs of people from rural and remote areas. Services are concerned about the possible presence of men in the hospital precinct and unprofessional practices which currently occur within mental health services, also occurring within sexual assault services. A matter of particular concern is hospital staff entering rooms without invitation and putting the woman's privacy at risk.

This model would place existing cooperation and collaboration at risk, and could be expected to result in a significant reduction in services in (particularly smaller) rural and remote communities. Since effective service provision in rural and remote communities varies according to the services and cultural attitudes in each town/community. A *consistent* systemic response could not address the particular needs of women from outside the greater Brisbane area. Further, given that most Queensland Health staff do not have strong community connections, and that community education and prevention typically falls outside their job roles, it could not address the social and cultural attitudes that legitimise sexual assault in some communities.

Women from other particularly disadvantaged populations often have a history of institutionalisation. The more institutionalised a woman's background, the more complex her needs, and the less suitable a hub approach. The high level of needs amongst disadvantaged women is an indication of the failure of mainstream services to meet their needs in the past. <u>The women who use specialist services have already *by-passed* the hub!</u> Given the financial situation of women from disadvantaged groups, most rely on free services. If a hub was the only available free service, many would receive no support at all.

Sexual assault issues can be very complex and multi-layered. Women with additional barriers experience additional complexities. Replacing specialist services with a generic service means that even if workers are aware of the particular needs of specific groups of women, reduced frequency of working with a specialist target group will mean that these specific issues will not be at the forefront when working with them and

are likely to fade into the background of their *tool kit*. Retrieving them occasionally means that specific expertise may not come to the forefront for a worker when it is needed.

Disadvantaged groups of women are even less likely than women in the wider population to report a sexual assault within the first 72 hours. They are typically less aware of their rights, and are therefore at higher risk of sexual violence. Most come from low socio-economic backgrounds (or have limited access to money in their own right). Many women lack social and family support systems. Sexual assault impacts every area of disadvantaged women's lives because every aspect of their life is already hypersensitive - most are *living on a tightrope*. The impact of sexual assault on all aspects of a woman's life is accentuated for disadvantaged groups of women. An experience of sexual assault generally compounds pre-existing problems such as homelessness, isolation, substance abuse or mental health issues.

Most women from specialist populations have a fundamental mistrust of government institutions. Many have a history of institutionalisation through systems such as the child protection, mental health and juvenile/criminal justice systems. Women from disadvantaged populations frequently have an adverse history with authority. Many fear *men in uniform* as a result of adverse experiences with (including sexual assault by) police or other armed service personnel (in Australia or their country of origin). Further, some women have outstanding warrants, and are naturally cautious about reporting a sexual assault to the police.

Women with a fear of government institutions typically have complex needs in their lives more widely, and these become entangled and inter-connected with their experience of sexual assault. As a result, most are cautious about using mainstream services or going into an authoritative environment, such as a hospital or police station, for help. If they do seek help through mainstream services, these women are at particular risk of being misdiagnosed or getting no service at all. Sometimes this occurs due to misunderstanding of, or assumptions about, their behaviour. For example, many women have ended up with a mental health record as a result of appearing confused or disoriented (because they don't understand what a *professional* is saying), being substance-affected or angry. Some experience a punitive response (eg. security are called in) and no service is provided in relation to their sexual assault at all. Further, past sexual assault often underlies later, inappropriate, mental health diagnoses or treatment for substance abuse. These women often need to address problems arising from their experiences of systemic responses, such control issues, de-personalisation and systems damage.

The Immigrant Women's Support Service (IWSS) has consistently found that a warm, non-threatening, home-like, comfortable physical setting offers the greatest likelihood that **NESB women, including refugee women,** will access services. The hub model suggested would provide an inappropriate response to most women from NESB who have experienced sexual assault. Any attempt to mainstream sexual assault services would result in a loss of services to many NESB women. Many women clearly state that they would not go to a formal environment such as a hospital or police station in order to seek help to address sexual violence. This is particularly true of refugee women who may have come from countries where state sanctioned torture, violence and corruption regularly occur. Further, a medically-driven model fails to recognise the intersection between NESB women's multi-faceted needs in areas such as legal proceedings, immigration, housing, income, criminalisation and their child-related needs.

According to the WWILD Sexual Assault Service, many **women with intellectual and learning disabilities** are institutionalised and comply with authority figures (eg. doctors, carers or police). They are at risk of saying and doing what they think authorities want to hear, rather than addressing their needs related to sexual assault. Others respond in an oppositional way toward authority figures. Without specialist, skilled support, these women may be misdiagnosed, penalised, or receive *assistance* that doesn't acknowledge or fulfil their needs. They are at risk of being labelled, resulting in an inability to access care, as demonstrated by *Patricia's* story:

> *Patricia* came to counselling with quite severe physical symptoms – slurred speech with lack of balance and co-ordination. She expressed anxiety about previous experiences when attending a public hospital. She told of being removed by security for what was labelled drunken, violent and aggressive

behaviour. She felt that they don't listen and she told how she then gets frustrated.

I offered to go with her to the hospital. When we presented at emergency and she gave her Medicare number, she was challenged about why she was there. This assertive challenge resulted in her becoming defensive, and she started to raise her voice and demanded to know why she couldn't see a doctor. I was able to intervene and prevent this escalating. With Patricia's permission I spoke to the doctor, her file was labelled "alcoholic, violent and aggressive" but included no mention of an intellectual disability.

A lifetime of masking her disability and the difficulty in understanding what was required of her had Patricia responding with fear and defensive behaviours. Specialist intervention allowed medical staff to have some understanding and gave Patricia a way to explain her fear and uncertainty. (WWILD sexual assault counsellor)

The hub model would be unlikely to address the barriers to accessing, and receiving appropriate support from, mainstream services for women with intellectual disabilities.

These women often struggle with any abstract concepts covered by generic medical forms. When completing these universal medical *tick and flick* forms, some will try to please through answering questions with compliance whilst others might show complete negativity. Many women with an intellectual disability would struggle to grasp the abstract concepts underpinning questions such as: *Using a level from 1 to 10 how angry do you feel?* They typically become anxious and either don't answer the question, or answer in a way they think shows co-operation. This places these women at risk of misdiagnosis.

Many women with intellectual disabilities are anxious about approaching government services. Many have a history of being misunderstood by government workers. Many are unable to express their needs within the short time allowed for typical interviews. Based on their previous experiences, many simply do not trust that they will be heard.

The physical environment of typical government facilities do not allow for the type of service provision which many women with intellectual disability have found helpful. This includes the space to engage in informal group work and interaction with other women with an intellectual disability, free of the pressure to mask their disability.

Sisters Inside believes that the hub model would be highly inappropriate for **criminalised women.** At the most obvious level, the hub model proposed by KPMG would preclude services to women prisoners, since they couldn't attend a hub! Application of the types of service delivery principles proposed by KPMG would serve to preclude criminalised women from accessing any sexual assault services. Research conducted for Queensland Corrective Services (QCS)[22] found that criminalised women do not usually use generic health services. Most women prisoners have complex, inter-related problems which mean they fall between the gaps in systems, are often poorly diagnosed and don't receive the range of concurrent services required to address their multi-faceted needs. For example, Queensland Health community mental health services consistently fail to provide services to women concurrently facing 2 problems (eg. mental health issues and substance abuse issues, or mental health issues and homelessness). Effective sexual assault support would require services to address the full range of issues facing criminalised women.

Most criminalised women's lives have been consumed and controlled by government authorities (including, police, QCS, child protection, Centrelink and mental health) for many years. Most criminalised women are particularly unwilling to use systemic services, because of their prior experience of police and hospitals. Their previous history leaves them particularly vulnerable to being disbelieved, further criminalised and/or misdiagnosed. Women will only use a service where their privacy is stringently respected and information is not shared with the police (or any other party) without their consent.

Zig Zag Young Women's Resource Centre has found that many professionals do not understand the context of some **young women's** lives - particularly the racism and marginalisation faced by many. Most do not understand the diversity

of sexual violence affecting young women - currently *sexting* and other coercion/ bargaining strategies.

The KPMG model would not meet the needs of young women. Zig Zag has frequently experienced the inability of existing mainstream systems (including police, courts and medical systems) to address the needs of young women who have been sexually assaulted. Advocacy on behalf of young women with these systems is often essential to ensuring that their needs are identified and addressed. Too often, hospitals have treated complex issues associated with sexual assault (eg. suicidal ideation or self harm) as a singular *black and white* mental health situation. Young women have been placed for 3 days in a mental health unit, with no further follow-up or help in relation to their range of needs, including needs directly related to their sexual assault.

Even if they are clear about having been sexually assaulted, many young women are uncomfortable with both government services, and services that are explicitly labelled *sexual assault* services. Young women have repeatedly said that a medicalised response cannot possibly meet their needs:

> *For me, it's nice to come into a more homely setting because I come here for counselling and not something medical. There's just something about working in a support building that has colourful walls; that is unique.* (Young Zig Zag participant)

> *… It's critical that young women have someone to sit with them and help them understand where they sit…* (Specialist sexual assault counsellor, Zig Zag)

Given the limited mobility of young women, many would find it difficult to safely approach a hospital-based service without being tracked by their family, particularly their perpetrator. Many would find it impossible to function within a conventional appointment system, or access different types of help from different *professionals*.

Discriminating against Indigenous women

According to Murrigunyah, Aboriginal women simply wouldn't go to a hub to address their sexual assault needs. An institutionally-based, government-run hub would represent the very power and control issues that Aboriginal women have already experienced through sexual assault. The proposed hub model is counter to national agreements made by the Queensland Government and the best Indigenous advice on Aboriginal Health Promotion[23]. It is inconsistent with the COAG Mental Health Plan, would represent a failure by the Queensland Government to meet its *Close the Gap* commitments, and is inconsistent with the *United Nation Declaration of the Rights of Indigenous Peoples* (to which Australia has agreed to become a signatory[24]). All these agreements focus on the active involvement of Indigenous people in the development of priorities and strategies, and in provision of services. The UN Declaration highlights Indigenous people's *right of access, without any discrimination to all social and health services* (Article 24.1).

The hub model offers nothing toward redressing the injustices of dispossessions. It appears that KPMG did not consult with Indigenous-specific health services, Elders, Traditional Owners or Healing Foundation committee members about how to best provide services to Indigenous Queenslanders. The hub model would potentially lead to further reduction in services to Indigenous people, rather than *closing the gap*. This approach would only <u>further</u> isolate, disadvantage, marginalise and disempower Aboriginal women.

There is little to distinguish the proposed hub model, from the wider Queensland mental health services model, which has been patently ineffective in meeting the needs of Aboriginal women. To date, Queensland Health services have a poor record in addressing co-morbidities faced by Aboriginal women, including intergenerational trauma, practical/material issues, mental health issues and sexual assault issues. Aboriginal women report that *professional* counsellors typically see issues such as housing or income, as unrelated to sexual assault. *Professional* counsellors often fail to understand that Aboriginal women may not be

able to discuss what's happened with their family, or tell particular people about their sexual assault. Group work, in particular, requires great caution and sophisticated cultural understanding. Actual harm has been caused to some Aboriginal women through culturally inappropriate practice. The current lack of Indigenous workers and services within Queensland Health makes it unlikely that an appropriate Indigenous framework could be incorporated within such a setting. Aboriginal workers are rarely employed in Queensland Health facilities (often due to their criminalisation), and would be unlikely to be employed in these hubs.

Conventional western psychological testing and treatment has a poor outcome for Indigenous people. Psychological testing has been demonstrated to be ethno-centric, inappropriate in most circumstances, and to result in a negative score bias against Indigenous people. Aboriginal people commonly find that the cultural norms of people trained in the medical model mean that it is difficult for them to be listened to or heard.

It is absolutely culturally inappropriate to co-locate services for Aboriginal men and women who have survived sexual violence. *Women's business* and *men's business* must be addressed in separate settings, by different community members, in different ways. Neither women nor men would feel safe if the other sex is present in the same service environment, such as the proposed hubs.

Threat to confidentiality and privacy

Signage is an inevitable component of large institutions. Women have widely commented on their caution about approaching a service which is labelled *sexual assault*. Further, when presenting at an emergency department, victims are likely to be required to initially explain their situation to reception staff. This particularly raises issues of privacy for people presenting to smaller rural hospitals, following sexual assault.

Current access to community-based services can be achieved with high levels of protection to service users' confidentiality. This would be compromised in Queensland Health settings where a range of health services are offered thereby increasing the chances that someone known to the client is also accessing another health service at the same location.

Women's confidentiality and privacy would be further threatened by the approach to information sharing, proposed as part of the KPMG model. Case conferencing is the most common form of information sharing amongst government service providers. Here, a person's needs are identified by professionals and a group of workers, each functioning within a narrowly defined role, decide who should to meet specific client needs. This functions counter to the need for women to be able to take control over the process of support, and their lives more widely, following sexual assault. It does not allow women to identify their own priorities and needs, and access the services required to meet these. Information sharing with police without the woman's permission would further undermine women's power.

Proposed easing of service users' right to privacy and confidentiality would serve as a further barrier to accessing a hub. Many women presenting at non-government services are afraid that their information will be shared. This is particularly common amongst women from disadvantaged groups. Many are worried that if they tell a worker what has happened, they will upset others or be expected to report to police. Interagency cooperation is essential to successful service delivery with people who have been sexually assaulted. Information sharing with a woman's express, informed, written consent, can be helpful for the woman herself and service providers. However, successful collaboration can equally occur in situations where women choose not to have their information shared.

Increased risk of systemic abuse

As recognised by KPMG, at least 50% of women who have been sexually assaulted face issues related to their assault in later life. Re-traumatisation can result from a wide variety of factors. Two of the most common triggers are an experience involving lack of control, and dealing with male authority figures. The 'hub' concept could be expected to expose women to these risks more often than is currently the case.

It is not uncommon for women to respond behaviourally to trauma or re-traumatisation.

Some withdraw; others strike out. Many examples are available of situations where women have been systemically penalised for their sexual assault. Hospital staff lacking specialist sexual assault competencies often respond to the **symptoms** (women's behaviour) and the woman is not diagnosed and/or treated for the **cause** (sexual assault):

- Many distressed women have been admitted to a Mental Health Unit. As a result they have a permanent mental health record as a result of their sexual assault. Some have been diagnosed *paranoid delusional* (or similar) and their sexual assault has been disbelieved. Some have been *depressed* (or similar) and treatment for depression has superceded any treatment related to their sexual assault.
- Some distressed women have been criminalised, when police or security are called in response to their behaviour. Similarly, women who are substance-affected (particularly Indigenous women) have often had their sexual assault disbelieved.

Experiences such as these can have life-long repercussions for women who have been sexually assaulted.

At a practical level, co-location of counselling for men and women within a hub could result in further trauma for a woman who has been sexually assaulted. Men who have been sexually assaulted are also sometimes perpetrators of violence. There is potential for a male perpetrator to be accessing sexual assault counselling, with a woman he assaulted presenting in a waiting area at the same time and for this not to be identified until it is too late:

> *As well as being a minority group of victims, males are also the majority of offenders. This raises ethical and practical issues for service delivery such as: How do we deal with male victims who are also perpetrators of sexual violence and disclose their own abusive behaviours sometimes months into counselling? How do males and females feel about sitting together in specialist services?* (Crome 2006, p 7)

Undermining the entire service delivery system

KPMG proposes that Queensland Health should consider de-funding all generic urban and rural community-based services[25] and precluding specialist services from providing direct service delivery[26]. This paper has already demonstrated the likelihood that replacing the current suite of services with a single approach to service delivery will significantly reduce the number of victims and survivors of sexual abuse who will receive support. It has further demonstrated that such a strategy would be wholly inconsistent with national policy on reducing violence against women and children and various COAG agreements.

The KPMG proposal that all direct service provision be mainstreamed is particularly contrary to the interests of women from populations with high levels of sexual violence. The inadequacy of the health, criminal justice and other systems to respond to the needs of women, both in specialist groups and more widely, is reflected in the high level of demand for community-based services. All services report frequent incidents of actual harm being done to women by these systems. Any decision to de-fund community-wide services, or reduce their capacity to provide community education and services to women, would only serve to reduce the number of these women receiving any support following sexual assault. Any decision to reduce the role of specialist services to providing *expert statewide secondary consultation to hubs*[27] would function to directly undermine the human rights of disadvantaged women.

The KPMG report includes no mention of how the community education and prevention currently undertaken by community-based services would occur under its proposed model. Government workers cannot speak out publicly about systemic barriers for women who have been sexually assaulted. Role constraints would make it almost impossible for Queensland Health staff to advocate for individual clients or provide community education. The limited connections of Queensland Health staff with rural and specialist communities would further reduce their capacity to provide customised prevention activities.

It is difficult to see how Queensland Health staff would implement a range of community awareness raising strategies encouraging the whole community to work together towards the elimination of sexual violence. Staff would be unable to respond quickly to address sexual assault issues and incidents, and unacceptable community attitudes toward sexual violence. They would be unable to produce media releases and facilitate community participation in wider anti-violence events. The medicalised approach to counselling proposed would preclude much of the integration of education and intervention which currently meets the needs of many women who have been sexually assaulted.

The KPMG proposal effectively silences sexual assault as a social and cultural issue, and treats it as an individual medical problem. If Queensland Health continues to move toward a more forensic approach to service provision, this will effectively eliminate the range of community education and prevention activities which are currently largely provided by non-government sexual assault services.

> *By focusing on the victim/survivors as a person with a mental illness needing treatment, attention is deflected from the social causation of rape and the generalised oppression of women.* (Astbury 2006, p 5)

Individualising sexual assault would invariably silence discussion of sexual violence and its causes. In practice, therefore, it would serve to condone sexual violence.

References

2002 Sydney Consensus Statement on *Principles for Better Practice in Aboriginal Health Promotion* in Australian Indigenous Health InfoNet (2005), *Summary of developments in Indigenous health promotion* at: http://healthinfonet.ecu.edu.au/health-systems/health-promotion/reviews/our-review

Astbury, J. (2006) *Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia*, in **Issues**, Australian Centre for Study of Sexual Assault, No 6 December

Australian Bureau of Statistics (2004), **Sexual Assault in Australia: A statistical overview***,* Australian Government Publishing Service, Canberra

BRISSC - Brisbane Rape Incest Survivors Support Centre (2009) **Your Views on Sexual Violence Survey**, online survey conducted by BRISSC in 2009, unpublished to date.

Crome, Sarah (2006) *Male Survivors of Sexual Assault and Rape,* in ACSSA **Wrap** No 2 September

Hockings, B.A.; Young, M.; Falconer, A.; & O'Rourke, P.K. (2002), **Queensland Women Prisoners' Health Survey**, Department of Corrective Services, Brisbane at www.correctiveservices.Queensland.gov.au/Publications/Corporate_Publications/Strategic_Documents/health_survey.pdf

Hubble, Mark A.; Duncan, Barry L.; & Miller, Scott D. (1999) **The Heart & Soul of Change: What Works in Therapy**, American Psychological Association, Washington DC

KPMG (2009) **Review of Queensland Health Responses to Adult Victims of Sexual Assault**, Queensland Health, Brisbane

Lambert, Michael J. (1992) *Psychotherapy Outcome Research: Implications for Integrative and Eclectic Therapists*, in Norcross, John C & Goldfried, Marin R (eds) **Handbook of Psychotherapy Integration**, Basic Books, A Division of Harper Collins Publishers, New York

National Council to Reduce Violence Against Women and Their Children (2009b), ***Time for Action*: The National Council's Pan for Australia to Reduce Violence Against Women and Their Children 2009 - 2021 - A Snapshot**, author, at http://www.fahcsia.gov.au/sa/women/pubs/violence/np_time_for_action/Pages/default.aspx

End Notes

[1] KPMG 2009, p 12
[2] KPMG 2009, p 7
[3] KPMG 2009, p 1
[4] ABS 1996 cited in: Australian Bureau of Statistics 2004
[5] Cited in: Australian Bureau of Statistics 2004.
[6] Services have been told that Queensland Health intend to publish this data, however it is not yet available.
[7] BRISSC 2009
[8] KPMG 2009, p 10
[9] KPMG 2009, p 11
[10] KPMG 2009, p 10
[11] Many less than the total of 15% of victims who report their assault at some time in their life.
[12] KPMG 2009, p 10
[13] KPMG 2009, p 9
[14] See for example Hubble et al 1999; Lambert 1992.
[15] LGBT - Lesbian, gay, bi-sexual and transgender
[16] KPMG 2009, p 7
[17] ABS 1996 cited in: Australian Bureau of Statistics 2004
[18] Cited in: Australian Bureau of Statistics 2004
[19] Women who saw a single counsellor at Phoenix House, Bundaberg on 10 May 2010.
[20] BRISSC 2009.
[21] National Council to Reduce Violence Against Women and Their Children 2009b, p 5
[22] Hockings et al 2002
[23] See for example the 2002 Sydney Consensus Statement
[24] Australia committed to support this UN instrument in March 2009, http://news.smh.com.au/breaking-news-national/australia-backs-un-on-indigenous-rights-20090326-9buw.html
[25] KPMG 2009, p 12
[26] KPMG 2009, p 34
[27] KPMG 2009, p 34