Feedback Paper

Moving Forward Information Sessions

This paper provides a summary of the views of stakeholders who participated in information sessions held around Queensland in November and December 2009. These sessions sought feedback about the KPMG Report on the adult sexual assault system in Queensland and initial ideas for moving forward.

Spall Watters Group

December, 2009

SPALL WATTERS GROUP
PARTNERS IN organisational capability

Contents

1. Information Session Overview

1.1 Background

In 2008, Queensland Health engaged KPMG to review the current adult sexual assault service system in Queensland. The KPMG report was released by Queensland Health to key stakeholders in October 2009 and the report was posted on the Queensland Health internet. The KPMG report

- Examined the current sexual assault system in Queensland, particularly responses provided by Queensland Health (QH) including services funded through the Sexual Assault Support & Prevention Program (SASPP)
- Made comment on cross jurisdictional functions
- Explored elements of best practice in sexual assault responses (with reference to evidence based approaches)
- Made recommendations for a way forward.

Queensland Health initiated statewide information sessions targeting health stakeholders to

- Provide information about the KPMG report review findings
- Seek feedback on the KPMG report findings including stakeholders' initial ideas about improved responses
- Have open communication and share views.

1.2 Participation at Information Sessions

Ten information sessions were held in November and December 2009 in the locations of Toowoomba, Gold Coast, Brisbane South, Brisbane North, Nambour, Rockhampton, Mackay, Bundaberg, Cairns and Townsville. There were two sessions which involved teleconference participation in Roma (Toowoomba and Mackay) and one session involved a videoconference link with Mt Isa (Townsville).

In total 153 participants from diverse professional groups and locations attended the information sessions (see Appendix 1 for list of participants). Appendix 2 provides the attendance of participants across locations and an indication of how many participants had accessed the KPMG report. Approximately 73% of participants had accessed the KPMG report, of those approximately 24% had read the full report[1]. This means that some participants attended the Information sessions for the primary purpose of understanding the KPMG report findings.

During the information sessions a range of questions were received on notice. These questions are outlined in Appendix 3.

Participants were asked to review the butcher's paper notes taken at each session and were asked to affirm whether these notes were an accurate record of the session feedback. The information sessions were facilitated by Shirley Watters and Pam Spall from the Spall Watters Group, an independent consultancy group in the health and community services industry.

[1] This figure is approximate due to late arrivals to sessions and some allowance for other discrepancies.

1.3 This Report

This report follows the format of the information sessions, which used four Discussion Points

- Additional issues and/or comments on the KPMG report
- Feedback on proposed high level system principles
- In taking the next step, initial ideas for improvement
- Comments on the proposal to establish an Advisory Group.

This report covers the feedback from information sessions. To keep the report to a workable size, the main discussion is documented. Some of the very specific location discussions have not been included. Four additional written papers from individual agencies were received by the consultants. Due to the size of these papers they are provided as an attachment to this feedback paper. The attachment contains papers from Phoenix House, Tablelands Sexual Assault Service, Gold Coast Centre Against Sexual Violence (GCCASV) and LivingWell. The papers from Phoenix House, Tablelands Sexual Assault Service and GCCASV are consistent and affirming of much of the feedback in this report. The paper from LivingWell largely covers services to men. Some of the material from these papers is drawn on in this report however readers are encouraged to separately access these papers for more detail.

The session at which a particular issue was raised is documented and at times (or where possible) recorded as Non-Government Organisation (NGO) or Queensland Health (QH) comment/issue. This does not necessarily infer that all participants supported or agreed with the issue. Individual services are referred to on occasion particularly the issues/comments from the written papers. Approval has been sought from these agencies to distribute and refer to their papers.

2. Feedback on KPMG Report

A brief overview was provided at the information sessions on the KPMG report under the headings of

- Integrated governance
- Variation in service delivery responses
- Local service coordination
- Client entry points
- Client group inclusivity
- Responses to Indigenous and CALD
- Qualifications and professional development.

Participants were not asked to reflect on the strengths of the KPMG report rather any gaps or other issues.

2.1 KPMG Report – Additional Issues

Discussion Point 1.

- From the KPMG report, are there any additional issues that have not been mentioned that you believe are important?
- Any overall comments about the KPMG report's assessment of the current system?

Additional issues raised were -

- **Role of Prevention and Education**

Participants critiqued the KPMG report for limited attention to prevention and education, particularly given that only a small percentage of victim's report sexual assault (Brisbane North; Gold Coast; Brisbane South; Rockhampton; Toowoomba sessions).

- **Linkages with Other Policy Agendas**

At the Brisbane South and Gold Coast sessions some NGOs stated that the report does not adequately link sexual assault with the wider violence against women agenda and Council of Australian Governments (COAG) health reforms. The LivingWell paper also raised the linkages with the National Men's Health Policy and Strategy.

- **Recognition of and Documentation of Current Service Delivery System and Past Achievements**

Standards

- NGO participants at the Gold Coast and Brisbane North sessions (and Phoenix House paper) stated that the report does not sufficiently recognise or document the development of standards by sexual assault service providers and the existing voluntary compliance with these standards (National Standards of Practice Manual for Services Against Sexual Violence 1998). Also noted was the role that Canadian Sexual Assault Standards played in continuous improvement for one NGO at the Gold Coast session.

Practice Framework

- NGOs attending the Brisbane North session stated that they were of the view that whilst the KPMG report critiques the sector for not having a well developed counselling and support practice framework, the consultation process did not sufficiently request or 'draw out' the existing practice framework of SASPP services, particularly NGO services .

NGO Sexual Assault Services

- NGOs attending the Brisbane South and Bundaberg sessions conveyed disappointment that the KPMG report did not adequately acknowledge the role played by NGO services in responding to recent victims and delivering a range of professional (not 'cottage industry') services. This issue is also covered in the Gold Coast Centre Against Sexual Violence written paper. Queensland Health participants in many other locations spoke highly of the services delivered by NGO's, particularly at the Nambour session.

Existing Partnerships and Linkages

Participants at four of the sessions (Gold Coast, Bundaberg, Mackay and Cairns) believed the report did not sufficiently document the range of existing partnerships and collaborative work being undertaken on coordinated responses across the State.

- **Focus on Acute**

Participants, particularly NGO's believed that the 'bias' and/or primary focus of the KPMG report on the acute response was overly 'clinical, medical and stigmatising of survivors' (Brisbane South; Bundaberg; Brisbane North; Cairns; Gold Coast sessions). Some participants at the Nambour and Townsville sessions were concerned that the focus on acute might force victims into Emergency Departments at the expense of funding commitments to other specialist responses. Participants at the Cairns and Rockhampton sessions indicated that the focus on acute will not work for rural and remote areas where 'many doors' are required.

- **Adaptable & Flexible Responses vs. Prescribed Responses**

Participants at the Gold Coast and Brisbane North sessions expressed concern that a consistent framework to service delivery as described in the report could negatively impact on local flexibility and responses to diverse client and population needs.

- **Hub Model**

Co-located services in Emergency Departments and 'centralised expert' hub models were critiqued at the Gold Coast and Brisbane South sessions as not necessarily equating with best practice client outcomes[2] and providing accessibility and choice for all victims, particularly those who don't want to report. NGOs at the Brisbane South session indicated that there were positive models of coordinated responses in other states that were not co-located models. Some participants at the Cairns and other regional sessions believed that the report did not adequately address appropriate models for Indigenous peoples. The Tablelands service gave examples of the barriers and difficulties to accessing Indigenous victims.

- **Choice in Gathering of Forensic Evidence**

Comments made predominantly from NGOs at all sessions were that a woman should have the right to a forensic examination without making a complaint as well as choice in the timing of a forensic examination and retention of forensic evidence. QH Forensic Medical Officers and Nurses present at sessions where these suggestions were made indicated that forensic examinations must be timely to preserve evidence (Bundaberg; Brisbane South; Gold Coast sessions).

- **Impact of Trauma on Workers**

Participants at the Gold Coast and Brisbane South sessions felt there was inadequate attention in the report to the impact of trauma on workers. QH and NGO participants at the Cairns, Brisbane South, Rockhampton and Toowoomba sessions all spoke of the significant impact of this type of work on the retention of staff.

[2] For example, there could be long waits in emergency departments when police not involved; the physical environment is often intimidating and no separate facilities available for victims.

2.2 KPMG Report - Assessment of Current System

- **Best Practice and Evidence Based Methodology**

A common critique of the KPMG report, particularly by but not exclusive to NGO's, was the limited clarity about how the best practice methodology was chosen to assess the service system, what criteria was used to select best practice elements and ways of responding, what was the literature database at both a national and international level, what assumptions were made in choosing and highlighting certain evidence, and why some best practice responses and elements were not carried forward into the recommendations (Brisbane North; Gold Coast; Brisbane South; Bundaberg; Cairns sessions). Also comments were made about areas where there is scant best practice evidence (often because the research has not been conducted) such as with CALD victims and the long term response to victims. Participants requested further information about how the report might have assessed the evidence (Brisbane North; Cairns; Gold Coast; Brisbane South; Bundaberg sessions). Participants at the Gold Coast information session stated that the Victorian pilot example provided of best practice in the report had not yet been formally evaluated, so no reliance could be placed on this service model as effective. Also an NGO at the Gold Coast session sought more specific information on the evidence base available to support women and men accessing the same service outlet. Some factual data[3] presented in the report was also queried such as ABS data on numbers of male victims. These issues are articulated further in the GCCASV paper (see Attachment).

Concern was expressed about the emphasis given to cognitive behaviour therapy (CBT) as an approach to trauma at the expense of other approaches[4] (Brisbane South; Bundaberg; Cairns sessions). The Tablelands paper discusses this point in some depth. At the Cairns session it was stated that good client outcomes could be primarily due to the therapeutic relationship formed with the counsellor rather than the intervention technique. Concern was also expressed that using a prescriptive approach to therapy such as CBT was not helpful to certain populations such as Indigenous victims (Cairns) and CALD victims - Sudanese clients (Brisbane North session).

- **Analysis Methods**

Participants at the Rockhampton session indicated that the KPMG report 'was comprehensive, named the issues and was consistent with their experience'. There were a range of other views about omissions and gaps in analysis

Gendered or Feminist Analysis

- Several sessions (Brisbane North; Gold Coast; Brisbane South; Bundaberg) indicated that should gender based analysis have been employed, the findings of the report might have been different, particularly in relation to the role and function of specific gender based service responses.

Historical Analysis

- A QH participant at the Bundaberg session indicated that the report lacked an historic analysis. This point was also raised at the Nambour session where a QH participant indicated that had the report used a full historical analysis of the evolution of service models and approaches in Queensland it could have demonstrated that NGOs in Queensland had been implementing a spoke model for over 15 years.

[3] See Page 37 of KPMG report.

[4] Some of the other approaches mentioned included narrative therapy, feminist theory and therapeutic approaches.

Managerialist Approach

- One Bundaberg participant believed that the report had an emphasis on managerialism and employed an efficiency methodology which is not helpful in delivering quality outcomes to consumers.

- **Sub Population Group Gaps**

Feedback from across most sessions indicated that the report did not provide adequate coverage of the range of issues and diversity of needs for sub-population and other groups such as

- Intellectual disability (Brisbane North)
- Women with a disability (Brisbane South; Gold Coast)
- Aboriginal and Torres Strait Islander peoples (Bundaberg; Rockhampton; Mackay; Toowoomba; Townsville; Cairns) including the colonisation of Indigenous peoples (Brisbane South; Bundaberg)
- LGBT (Brisbane South)
- Women in prison (Brisbane South)
- CALD (Brisbane South)
- Young people (Brisbane North; Brisbane South; Cairns)
- Historical abuse survivors (Brisbane North)
- Role of family and significant others and support to these groups (Gold Coast).

- **Voice of the Consumer**

At several sessions it was stated that the methodology was inappropriate in not giving voice to victim's experience of the existing service system and that this needed to be rectified (Gold Coast; Brisbane South; Bundaberg).

- **Sampling and Categorisation of Ratings**

The KPMG report finding that nowhere across the state were best practice elements 'consistently' applied was contested. A Bundaberg NGO believed that they do provide a 24 hour response and also respond consistently to ATSI people and CALD. Also another participant from the same NGO at the Bundaberg session critiqued the inferential sampling method used in the report and stated that greater reference and mapping should have occurred of local conditions and service systems.

3 Taking the Next Steps

3.1 System Principles

The information session outlined key principles to guide systems development

- Victim centred approach which is respectful, responsive, values and ensures that the person is able to make informed choices
- Timely response for those who require services
- Response is individualised depending on client needs, values and cultural identity
- Providing access to service that does not vary in quality because of sexuality, gender, culture and geographic location
- Delivery of services based on evidence based practice
- Collaboration between key stakeholders is a priority across the parts of the sexual assault system.

Discussion Point 2.

- Do you broadly support these principles?
- Are there any significant gaps?

There was broad support across all sessions for the principles with some indicating they already implement these principles (Bundaberg). Some additional comments made included

- The principles are aspirational. The difficulty is fully implementing these principles within the current resource level of the districts. Victims will miss out because of inadequate supply and gaps in service responses (Toowoomba; Nambour; Mackay; Townsville; Gold Coast)
- There are many practical challenges as well as geographic challenges in implementing these principles, particularly in rural and remote areas (Rockhampton; Cairns; Townsville)
- Need for a principle that recognises a statewide, cross-jurisdictional approach that is standardised, but with capacity for contextualising at a district level (Mackay)
- Need for a principle that recognises linkages with other corporate governance (e.g. Compact; Care Coordination) and other cross government initiatives (Toowoomba)
- The principle about collaboration needs to be further defined (Brisbane North). Also this principle needs to reflect not only collaboration but a commitment to partnering with other agencies (Toowoomba)
- A separate principle is required that recognises sexual assault as a qualified profession, which receives ongoing training, opportunities and rewards (Bundaberg)
- The principles as listed do not apply to group work (Brisbane North)
- Safety of the victim is paramount and should be a principle in its own right (Gold Coast).

The earlier comments made about the gap of prevention and education (Gold Coast session – see section 2.1); evidence based practice (Townsville; Mackay; Brisbane North sessions– see section 2.2); need for gendered analysis (Bundaberg session– see section 2.2); acute emphasis (Brisbane South session– see section 2.1); choice re timing of forensics and reporting (Brisbane South session – see section 2.1) were reiterated as points to take account of in the development of principles.

3.2 Service Delivery Improvement

The information session outlined key features of a service system, based on application of the KPMG findings including

- Health led approach
- Consistency of approach across state
- Integrated service response
- Evidence informed practice
- Inclusive adult focussed service delivery.

As a starting point, the session provided key items Queensland Health identified for improvement in the service delivery system including

- Have clearer established, identifiable and accessible entry points for victims
- Better integrate forensic, medical and psycho-social in a coordinated way
- Be inclusive of both female and male victims and be able to respond to diverse population groups
- Address issues of training and qualifications of staff who provide evidence based responses.

Discussion Point 3.

- About the Next Step, what are your initial ideas about improving responses to adult sexual assault?

Feedback by participants about improved responses to adult sexual assault included

- **A Shared Understanding**

Participants at a majority of the sessions agreed that the service system could be improved through a shared understanding around a legal definition and roles and responsibilities

- A shared definition of sexual assault consistent with legal definition including definitions of age of child.

- A shared understanding of the roles and responsibilities of agencies and positions (e.g. Forensic Nurse Examiners (FNEs) across government, the non-government sector, private sector and the wider service system in responding to adult sexual assault. At two sessions (e.g. Townsville; Toowoomba) participants indicated that training was required on interagency roles and responsibilities.

- Diverse comments were made about the inclusion of all key stakeholders (defined as per information session presentation) in the development of roles and responsibilities as well as Education Queensland; private counselling providers and specific statewide networks.

- Clarification of and agreement on the role of forensic services in reporting and 'just in case' forensics.

Prevention and Education

Several information sessions and papers raised the importance and need for prevention, education and information (Rockhampton; Cairns; Gold Coast; Brisbane North; Brisbane South; Toowoomba). The link between improving rates of under-reporting and public education was made. Participants requested the integration of prevention and education work into the service system and clarification of roles and responsibilities around prevention. At the Brisbane North session it was stated that a recent national research report on evidence based approaches to prevention and education could assist in the task.

Client Pathways

At a few of the sessions it was indicated that having access to 'core articulated' client pathways would be helpful and could be amended to the district situation. The Townsville session referred to 'client pathway points' and staff having knowledge about these points and available services. Two sessions (Townsville; Brisbane North) expressed concern about pathways from sexual assault into the mental health system. At the Cairns sessions, representatives from the Tablelands stated that the pathway for self-referred historical victims wanting counselling was not clear. The Cairns session also suggested that consumers should be involved in any client pathway project to gain a better understanding of entry points.

Health Led Approach

The proposal for a health led approach with QH leading governance, received reasonable support from sessions. At the Bundaberg session it was stated that it was irrelevant which government agency governed and held the funds, as long as it was a 'whole of government' approach and the systemic concept was 'a trauma specific approach'.

There was less support for QH leading the response through acute service delivery. Brisbane South NGO's at the Brisbane South session stated that a community led approach was a better option for both acute delivery and governance and referred to the effectiveness of the community undertaking this role in the past and other overseas successful models of community led governance such as the Duluth Model for Domestic Violence. Concerns voiced about QH leading acute service delivery were the current capacity of hospitals, likelihood of achieving an integrated response and the degree of expertise of hospital staff (see further explanation below). A number of Brisbane South participants from both QH and NGOs stated that they were concerned about the relationship between acute services and community support due to

- No agreed mechanisms for referral
- No clarity of roles
- No continuum of care across the sector
- No understanding of the coming together of acute and long term responses.

There was more support for capacity building of interagency governance processes and relationships at a district and local level. The proviso was that existing networks and processes not be overridden

> *My concern is that we have already invested in significant improvement, wouldn't want this work over-ridden or undone (referring to an integrated interagency response including protocols in Cairns). Maybe the focus should be on areas that need work such as Tablelands (NGO participant in Cairns).*

At the Toowoomba session there was a request for a revised 'multi-agency corporate governance' framework for better clarity of roles and responsibilities. A similar request was made at the Mackay session. Two locations suggested looking at interagency models in child protection which seemed to have been effective.

Suggestions for kick starting the process were

- Mapping current NGO and government service system and interagency relationships at a district and local level to understand what exists and how it works and what are the gaps (Gold Coast session)
- Development of Memorandums of Understanding between Queensland Health, Police and SASPP in each location (Bundaberg session)
- Costing per head of population what resources were required to implement possible options (Cairns session).

All locations specified flexibility at a district level was required to achieve effective implementation of any governance and policy initiatives.

Standards

The majority of locations had no issue with implementing quality standards. In addition, the Mackay session suggested benchmarks and performance indicators. NGOs at almost all sessions sought clarification about whether the existing national standards will suffice or another quality process is required.

- **Integrated and Coordinated Service Response**

A Viable Model for Emergency Departments

At the majority of sessions, participants did not have an issue with hospitals providing the acute 24/7 response particularly in larger centres. The concern related more to the current capacity of Emergency Departments to materialise an effective response to victim needs, particularly on

- Access to staff with specialist sexual assault and/or trauma training[5]
- No dedicated facilities in many locations (e.g. no comfortable room away from main waiting area for victims)
- No or limited access to social workers and/or forensic in some locations particularly on weekends and afterhours
- Waiting times for victims who were not accompanied by police
- Extremely limited psycho-social response particularly in rural and remote areas.

QH staff from some Emergency Departments present at information sessions stated that it might be difficult to design a viable Emergency Department integrated response to sexual assault when reporting was low, demand unpredictable and emergency departments frequently operate under extreme pressure. Additional resourcing was stated as a significant strategy to overcoming these issues. Mackay presented an example of 'making do' to make the system work where resources were scarce. This required flexibility with roles and functions across the stakeholders (Social Work, Obstetricians & Gynaecology, Emergency Department, and SASPP). Bundaberg commented that the practicality of implementing a co-located hospital model is not always feasible, citing

[5] Examples were given of staff not sufficiently trained in trauma and sexual assault occasionally resulting in mental health diagnosis (e.g. personality disorder) for post traumatic symptoms due to sexual assault (Townsville). Other challenging Emergency Department situations were raised across sessions.

attempts by the NGO to co-locate at the hospital thwarted by no available physical space and limited medical services. Instead victims are transported from the hospital to the GMO.

Hub and Spoke

The majority of locations did not reject the hub model outright. The concern with the hub and spoke model was the extent to which the model can be sufficiently adapted to local conditions and existing localised service delivery arrangements and partnerships. At the Brisbane North session the following comment was made: 'not one size fits all'. The other major concerns were the applicability of this model to all populations groups and all rural and remote circumstances; the availability of additional resources to coordinate a hub model and to fund the current gaps in the service system; and whether the model was sufficiently versatile to allow multiple client entry points.

Concerns were also raised across five locations that if the resource environment for improvement was 'cost neutral', then future decisions might see the redistribution of funds away from the spokes or specialist services, in favour of the co-located health led hub. NGO participants were more likely to support a networked or similar hub model. The paper by LivingWell contributes to an understanding of the exceptions to using a co-located hub model.

A NGO participant at the Bundaberg session believed the hub model was preferable as it devolved decision making to a district hub level rather than corporate/centralised decisions. The Townsville session indicated that the fax back model used in domestic violence had potential and it was currently being piloted in Townsville with a view to possible replication.

Participants at several sessions (e.g. Bundaberg; Cairns; Gold Coast; Townsville) were positive about the hub approach and called for the piloting of a hub model in different geographic and client contexts to gauge whether the model was workable and adaptable. At the Gold Coast session an NGO participant proposed two options, the 'aspirational' second option was for two centres of excellence that are connected, an acute health response and community based response. These options are outlined further in the GCCASV paper (see Attachment).

Also Cairns and Bundaberg sessions supported consultation with Indigenous consumers and piloting of new and innovative responses to Indigenous communities. The Living Well paper proposes possible models for Indigenous clients.

Three locations stated that in designing any new service system, attention must be given to the resourcing and integrated fit of the 1800 telephone line.

- **Inclusive Adult Focussed Service Delivery**

Men

Service responses to men vary considerably across the state and many of these examples were highlighted at the information sessions. For example, Cairns FNE's provide services to men however the Cairns NGO has no capacity to provide services to male victims of sexual assault due to limited funding but would extend the service if funded. Mackay SASPP provides services to women and men. A number of SASPP funded services indicated that 'they were open to considering how to work with men to facilitate access' (Townsville NGO). As the LivingWell paper outlines there are similarities in the experience of sexual assault between men and women. Tablelands NGO also clarified their position that 'we can provide services for men if safety for women and children is maintained.' Most services indicated that additional resources were required to provide a response to men. The LivingWell paper discusses the issues of a service delivery model that accommodates gender specific needs of women and men, and transgendered people. This paper also discusses dedicated

models and thinking about how to respond to men who have been sexually assaulted. The LivingWell paper grapples with many of the issues facing sub-populations of men and their different needs.

- **Professional Development**

There was significant support across all locations for enhanced professional development of staff. Professional development was viewed as including training, peer support, mentoring and professional supervision. A participant at the Bundaberg session stated that Queensland Health should also provide an 'enabling' strategy for sector development of SASPP agencies.

Discussion at some sessions (Toowoomba; Nambour; Townsville; Mackay) was about how staff particularly in Emergency Departments can be trained without losing the skills due to infrequency of use. Strategies for topping up skills and dealing with high staff turnover were discussed. Mackay participants discussed effective approaches to training such as 'simulated' skills training.

In Townsville a discussion about the use of generalist and/or specialist staff in Emergency Departments occurred. It was concluded that the answer depended on resources available, existing and surrounding service system, demand for service, geographic circumstances, and presenting victim needs.

Participants were encouraging of the newly developed Sexual Assault Worker Training. There was some concern from past SASPP experience about the capacity of Queensland Health to commit to rolling out training.

- **Resourcing Improvement**

The general consensus across information sessions was that within current resources some practical improvements could be made (e.g. developing flowcharts, clarifying roles at a local level etc) however these improvements were less likely to be significant improvements to the service system.

The majority of information sessions stated that if the goal of reform was to respond effectively to a wider group of clients such as younger ages, men, current non-service users, Indigenous peoples, CALD and the range of population groups listed in section 2.2 of this report, then additional funds were required. Toowoomba gave an example of requiring Indigenous Liaison Officers.

Rockhampton and other locations stated that interagency processes to improve integration, coordination and capacity building of the service system require resourcing. Cairns spoke of the considerable investment by agencies in relationship building processes (i.e. interagency protocol development) over a period of 18 months prior to achieving an outcome. This was a funded project.

4. Future Engagement Process

4.1 Feedback on Advisory Group

The information sessions advised participants that Queensland Health would be calling for Expressions of Interest (EOI) in early 2010 to establish an Advisory Group. The role of the Advisory Group is to 'oversee the development of key system improvements.'

Discussion Point 4.

- Do you have any comments about the proposed Advisory Group?

Comments provided about the Advisory Group included

- **Advisory Group Membership and Representation**

Participants stated that the membership of the Advisory Group needed to be diverse. Suggestions for possible membership included -

- Consumer/s (Victim/survivor group representation) (4). Townsville and Rockhampton referred to this as 'lived experience'
- Practitioners informed in rural and remote issues including lone workers (3)
- People with a disability (2)
- Indigenous and Torres Strait Islander participation (2)
- CALD (2)
- Mix of portfolio areas such as child protection (2), police and JAG (1)
- Mix of disciplines such FNE, counselling, medical (1)
- Non-government services (1)
- Men and women (1).

Several locations (Nambour; Toowoomba; Cairns; Townsville) were concerned that a representative selection is made of members from metropolitan, regional and rural and remote areas. Townsville indicated that there should be a higher representation of regional, rural and remote areas.

- **Method of Involvement**

Mackay requested that Advisory Group meetings are face-to-face. Nambour believed the process should be bottom up with Working Groups established at a District level that fed into corporate office rather than a corporate Advisory Group structure. Gold Coast requested co-chairing arrangements between government and non-government. Brisbane North wanted to know who the Advisory Group was advising.

- **Clarity of Brief**

Brisbane North and Mackay sessions made comments about the necessity for clear Terms of Reference around roles and responsibilities; clear understanding about sphere of influence[6] and reporting lines; clarity of communication mechanisms; and the nature of and flexibility of consultation and information gathering processes with other key stakeholders and interested parties to the Advisory Group.

- **Resources**

Participants at the Mackay, Toowoomba and Brisbane North sessions were concerned that the Advisory Group process is adequately resourced to enable participation by Districts. Toowoomba QH participants indicated that without resources for backfill, participation would be difficult for stretched services.

- **Timeframe**

A QH participant at the Cairns session praised the engagement processes for having a flexible timeframe. A NGO participant at the Townsville session critiqued this approach as creating uncertainty in planning and staffing, as NGO funding contracts expire in December 2010.

[6] This point referred to Advisory Group participants being fully aware of their relationship to hard decisions that might need to be made. Also which group will support the Advisory Group such as Executive Management Team.

4.2 Opportunity for Change

As a quick snapshot, participants at 9 of 10 locations[7] were asked to indicate their readiness to engage in improvements and change in the process of moving forward (see Appendix 4). The results for 8 sessions were

- 73% indicated they saw the process as an 'opportunity to embrace change and improve the current system'
- 16% were concerned about change on their role
- 03% were undecided
- 07% there was no response.

At one location individuals didn't respond to the snapshot process and this was read as concern about change.

A qualifier made about change was '*I support the process but only if the goal is client focussed improvements'.*

5. Conclusion

In moving forward, some of the strategies for change highlighted were

- Clarifying roles and responsibilities across government and the non government sectors
- Training to all staff responding to victims of sexual assault
- Mapping what currently exists including interagency responses and existing protocols and other initiatives
- Working together at a district and local level across all partners to improve client pathways and understanding of roles and responsibilities
- Understanding better and agreeing on a range of good practice approaches such as preferred approaches to working with victims; appropriate responses to Aboriginal and Torres Strait Islander peoples and rural and remote communities; models of practice incorporating female and male victims and other specialist groups
- Some practical improvements could be made within current resources however significant system change would require resource improvement.

The KPMG report identified significant improvements required in responding to diverse client needs. The information sessions commenced the process of taking the review report and discussing the implications of change particularly at the district and local level. For some participants this was the first time they had discussed the KPMG report findings. Other participants had a more thorough understanding of the recommendations and how these might impact on service delivery. Overall, the majority of participants welcomed the opportunity to improve the adult sexual assault service system and displayed a readiness to engage in the ongoing improvement process.

[7] It is unknown whether the inclusion of Brisbane North would have substantially altered the result.

Appendices

Appendix 1. List of Participants

Name	Position	Organisation
Toowoomba 10 November 2009		
Sandra Barrett	Social Worker	Queensland Health (QH)
Sheree Conroy	Doctor	QH
Sue Schmidt	Senior Social Worker	QH
Luke Tanks	Mental Health Service Integration Coordinator	QH
Mary Abbot	Nurse Director	QH
Rosemarie Kuby	A/Nurse Unit Manager Child Health	QH
Karen Fernie	Coordinator Sexual Assault Support Service	QH Toowoomba Hospital
Julie Campbell	Psychologist (Counsellor)	Sexual Assault Support Service QH Toowoomba Hospital
Jan Pemberton	Social Worker	QH – Toowoomba Hospital
Louise Judge	Coordinator South Burnett Women's Service	Centacare South Burnett
Laurel Cohen	South Burnett Women's Service	Centacare South Burnett
John Hooper	Director Public Medicine	QH
Judy Kelly	Sexual Assault Support & Prevention Service	South West HSD (linked by teleconference from Roma)
Gold Coast 11 November 2009		
Kym Bidgood	Clinical Nurse	Logan Hospital Emergency Dept
Cathy North	Senior Social Worker	West Morton Women's Health
Kim Bridgland	Social Worker	West Moreton Women's Health
Kevin McNamara	Director of Psychiatry	Mental Health and ATODS
Angela Driscoll	Management Committee	Gold Coast Centre Against Sexual

		Violence (GCCASV)
Betty Taylor	Management Committee	GCCASV
Donna Justo	Management	GCCASV
Di Macleod	Director	GCCASV
Michelle Daly	Director of Social Work	Gold Coast Health Service District (GCHSD)
Sarah Procopis	Social Worker – Emergency Dept	GCHSD
John Purton	Forensic Medical Officer (FMO)	Gold Coast Hospital
Anne Louise Swain	FMO	Clinical Forensic Medicine Unit (CFMU)
Cathy Lincoln	FMO	CFMU
Sally Jacobs	FMO	CFMU
Kyriaki Artis	Assistant Director Social Work Robina Hospital	Gold Coast Health Service District
Brisbane South 12 November 2009		
David Jardine	Senior Medical Officer (SMO)	Sexual Health
Gabrielle Shellon	Social Worker (SW)	QH
Katrina Weeks	Young Women's Counsellor	Centre Against Sexual Violence(CASV)
Melissa Langridge	Young Women's Counsellor	Centre Against Sexual violence
Debbie Aldridge	Manager	Centre Against Sexual Violence
Glenn Bradley	Executive Director Community & Primary Health Service	QH
Hans Braaksma	SW Allied Health Acute Stream (AHAS)	Logan Hospital
Nicola Hutley	Social Worker AHAS	Logan Hospital
Fran Nguyen	Emergency Department Logan RN	Logan Hospital
Joyce Westerman	Counsellor Project Worker	CASV
Brett Davies	Social Work	Logan Hospital
Carmel Perrett	Director Child & Youth Services	QH
Alice Fand	Social Worker	Logan Hospital

Michelle Pettinger	Social Worker	Redland Hospital
Rachel O'Connell	Social Worker	Logan Hospital
Martinya Barnjak	Social Worker	Child Health
Emma Harrington	Social Worker	Child Health
Rozanne Little	Social Worker	Child Health
James Wallace	Social Worker	Logan Hospital
Nicola Anderson	Child Protection Liaison Social Worker (CPLSW)	Logan
Barb Crossing	Management Committee	Women's Community Aid Association
Anna Gilet	Support, Group and Community Education Worker	Brisbane Rape and Incest Survivors Support Centre (BRISSC)
Karin Cheyne	Support Group & Community Education Worker	BRISSC
Stephanie Anne	Director	Immigrant Women's Support Service (IWSS)
Jane Hegerty		Zig Zag Sexual Assault
Brisbane North 12 November 2009		
Yasmine Hassan	Head of Counselling	DV Connect/SAHC
Di Mangan	Manager	DV Connect
Don Buchanan	Medical Officer	QH
Adam Griffin	FMO	QH
Christy McGuire	Coordinator	ZigZag
Mahala Jagoe	Counsellor	Redcliffe/Caboolture Sexual Assault
Elena McLeish	Clinical Nurse	QH
Kate Allen	Clinical Nurse	Brisbane Sexual Health Clinic
Margaret Mobbs	Visiting Medical officer	Brisbane Sexual Health Clinic
Georgia Ash	Snr Clinical Psychologist	Sexual Health and AIDS Counselling Service
Christine Riches	Social Worker Caboolture ED	QH

Tania Morfey	Assist Director Social Work	RBWH
Liz Waples	Social Worker RBWH	QH
Pamela McNeil	Senior Social Worker	Maternal and Neo RBWH Social Work
Sue Starrenburg	A/Senior Social Worker	Child Protection RBWH SW Services
David Higson	Assistant Nurse Director	Mental Health RBWH
Tuija Lindstrom	Coordinator	WWILD – SVP
Beata Ostapiej Piatkowski	SA Program Coordinator	IWSS
Heidi Bone	Admin/Coordinator	BRISSC
Gary Foster	Manager	Living Well
Cate Harvey	Metro Sexual Assault Counsellor	Living Well
Jane Amos	S/ Project Officer	QH
Jennie Broadhurst	Project Officer	QH
Jan Hinson	Director Social Work	RBWH
Nambour 16 November 2009		
Carolyn Walker	CNC	Mental Health Service NGH
Christine Scarvell	CNC	Mental Health Service SSCWB
Kirsty Edmonds	Forensic Nurse Examiner (FNE)	QH
Kimberley Milner	Nurse Unit Manager (NUM)	Gympie Department of Emergency Medicine (DEM)
Lisa Rasmussen	NUM	Nambour DEM
Lydia Mirabito	Clinic 87/FNE	QH
Sharon Young	CNC	Clinic 87 – QH
Beverly Wilson	Acting Nursing Service Director Emergency	Emergency – Southern Cluster
Tony Harrington	Senior Medical Officer	Nambour General Hospital (NGH)
Nola Powell	Social Worker	NGH
Helen Bruderer	Social Worker	NGH
Judy Benfer	Clinical Director; Senior Social Worker	Caloundra, Nambour

Vera Hempel	Director SW, Chair Allied Health SCHSP	Nambour Hospital
Bernadette Couch	ACPLO	NGH
Felicity Callanan	Senior Social Worker, Community and extended care	QH
Mary Watt	Acting T/L Psychologist	Redcliffe; Caboolture, Acute Care Team, MH
Carmel Barry	Acting Nurse Educator	Redcliffe, Caboolture, MHS
Karren Aspinall	Manager	SCSASV Inc – Laurel House
Lisa McLean	Team Leader	SCSASV Inc – Laurel House
Nicole Duthie	Social Worker	Redcliffe Emergency Dept
Heather Jobson	Clinical Nurse	Nambour Hospital MHS
Debbie Ansell	FNE	Sunshine Coast
Rockhampton 17 November 2009		
Karen Briggs	Sexual Assault Worker	Rockhampton Rape Incest and Sexual Violence Centre
Vicki Lahtinen	Manager	Women's Health Rockhampton
Darren Holzberger	Director of Nursing (DON)	Primary Community Health Service
Natalie Stewart	FNE	Community Health Rockhampton
Jenny Cockerill	Manager	Women's Health and Sexual Assault Service Gladstone
Kevin Flockhart	Social Worker	Q H
Meda Black	Social Worker	QH
Andrew Jarvis	Nursing Director - RM	QH/Rockhampton Hospital
Alison Ohara	Service Manager MHS	Gladstone MHS
Jan Randall	Num ED	Rockhampton Hospital
Simone Davies	CN	Yeppoon Hospital
Sue Cordell	FNE	QH/FPQ
Ajay Chipiri	SMO	ED Rockhampton
Tracey Schultz	FNE	QH/FPQ

Mackay 26 November 2009		
Anne Kelly	SW	Mackay Base Hospital (MBH)
Nikki France	SW - cancer	MBH
Annette Boyd	SW Womens	MBH
Nancy Young	SW	MBH
Paul Turner	SW	MBH
Lyn Radel	Nursing Director Community and Ambulatory Care	MBH/MCHC
Regina Coxon	SW	MBH
Justine Collins	Maternity Nurse Practitioner	MBH
Susan Ralph	Social Worker	MBH
Aaron Kennedy	Acting Director DEM	MBH
Hannah Lupo	SA Counsellor SHASA	Mackay Sexual Health
Christine McIllwhan	Coordinator SHASA	SHASA Community
Selena Miller	Roma Mental Health	QH – teleconference
Rowena Wilson	Social Work Roma QH	QH - teleconference
Bundaberg 1 December 2009		
Keiva Meyer	Social Work Manager	Bundaberg Hospital
Lou Gatti	Committee Member	Phoenix House
Kathy Prentice	Director	Phoenix House
Sheila Robbins	CPLO Social Worker & Management Committee	Phoenix House
Pam Brown		Gladstone Women's Health and Sexual Assault Service
Robyn Liddel		Gladstone Women's Health and Sexual Assault Service
Leonie Nord	Coordinator	Wide Bay Burnett Sexual Assault Service
Cairns 3 December 2009		
Rowena Chapman	Coordinator	Tablelands Sexual Assault

Josie Sataro-Webb	Committee Member	Tablelands Sexual Assault
Clare Oppy	Coordinator	FPQ Cairns Sexual Assault
Neil Springell	Social Worker	Qld Health
MidgeBalodis	Forensic Nurse Examiner	Cairns Base Hospital – Cairns
Carron Lodder	Forensic Nurse Examiner	Cairns Base Hospital
Townsville 4 December 2009		
Di Plumb	Senior Counsellor	Women's Centre
Cathy Crawford	Coordinator	The Women's Centre
Kadell Fotinos	Clinical Nurse	CFMU
Nicole Aitken	Clinical Nurse	CFMU
Melissa Illin	Admin Officer	CFMU
Dr Geoff Fisher	Deputy Director	CFMU
Belinda Vincent	Sexual Assault Counsellor	Women's Centre
Casey Channon	Sexual Assault Counsellor	Women's Centre
Jody Mogensen	A/Nurse Educator	The Townsville Hospital ED
Tanya Rees	RN	The Townsville Hospital ED
Leone Lovegrove	CNC	ED
Trish Rowan	Social Work	Social Work Dept
Jane Collger	Social Work	Social Work Dept
Francine Morison	Social Work	Social Work Dept
Barbara Gate	Director Allied Health	Mt Isa Health Service District (via telelink)
Melissa Slipper	Acting Director Social Work	Social Work Mt Isa (via telelink)

Appendix 2. Distribution of Participants by Location & Access to Report

This table provides an indication of the number of participants by location as well as who had accessed and read the full report. It is important to remember that three of the locations had participants linked in from rural and remote areas (Roma to Toowoomba, Roma to Mackay, Mt Isa to Townsville).

Information Site Session	# of Participants	Accessed Report	Read Full Report
Toowoomba	12	12	6
Gold Coast	15	15	8
Brisbane South	25	8	4
Brisbane North	24	23	10
Nambour	22	12	0
Rockhampton	14	14	0
Mackay	12	9	1
Bundaberg	7	6	3
Cairns	6	4	3
Townsville	16	9	2
TOTAL	153	113 (73%)	37 (24%)

Appendix 3. Questions Received On Notice

A number of questions were raised on notice at Information sessions. Participants requested answers to these questions. The method for answers was not determined but suggestions included the intranet website (e.g. Q & A). The table outlines the questions raised by Information session location.

Information Session Site	Question/s
Gold Coast	• How are other stakeholders (Justice; Police; Youth; Client groups including women with disabilities; CALD; Indigenous peoples; 24 hour telephone service) being engaged in this Information session process? • How does this process intend to link with Commonwealth health policy changes? • Has there been any acknowledgement and/or discussion about the demand on the wider service system from survivors of sexual assault such as private counselling practitioners, and how this will be managed moving forward? • What is the definition of the age of a child and an adult?
Brisbane South	• What resources will be available overall for the improvement process? • How will new target groups be resourced where an extension of service and/or better access to services is recommended in the KPMG report? • How will professional development be resourced? • How will coordination of agencies be resourced? • How can participants make additional formal feedback to Queensland Health about the KPMG report, as well as comment about who was invited to participate in these Information sessions? • How can participants to Information sessions access the feedback paper prepared by the consultants?
Brisbane North	• What is the process for making further submissions to the Information session process? • What does a 'health led' process mean? What is the scope of this approach and does it include justice and police? • How will the improved Queensland response to adult victims of sexual assault integrate with current proposed national initiatives? • How will cross government engagement occur? • How can participants access the Information session Feedback Paper? • How can participants access answers to questions on notice raised at Information

	sessions? • What is the current status of Queensland Health funding for young women aged 12 – 18 years?
Nambour	• Did an emergency clinician have input into the KPMG report? • What funding will be provided to implement change? • Is there any more detailed information available about which hub and spoke model Queensland Health might prefer? • Can it be assumed that Queensland Health will take account of existing site specific needs and expertise in any improvements made?
Rockhampton	• What is the definition of the age of an adult and child in responding to sexual assault? At present to what extent is this definition consistently applied?
Cairns	• How many hubs does Queensland Health intend to establish across Queensland? Will the hub structure mirror the Health Service District structure?
Townsville	• How can the feedback report from these Information sessions be accessed? • What is the intention of Queensland Health in responding to children? • What is the timeframe for completion of the continuous improvement process? Is there any acknowledgement of the current disruption to NGOs with contracts to December 2010 in terms of recruitment of staff, planning and ultimately service to clients?

Appendix 4. Readiness for Change

Information Session Site	# of Participants	a. Opportunity to embrace change and improve the current system	b. Of concern to me and my role	c. Undecided	d. No response
Toowoomba	12	5	4	1	2
Gold Coast	15	7	5	1	2
Nambour	22	12	6	0	4
Rockhampton	14	14	0	0	0
Mackay	12	12	0	0	0
Bundaberg	7	5	1	1	0
Cairns	6	5	1	0	0
Townsville	16	16	0	0	0
TOTAL	104	76 (73%)	17 (16%)	3 (03%)	8 (07%)

ATTACHMENT - Papers Received from Individual Agencies

During the course of the Information sessions, four agencies provided the consultant with copies of their individual agency comments and feedback on the KPMG report and other discussion points. Papers included in this Attachment are

- Phoenix House submitted by Kathy Prentice (3 pages)
- Tableland Sexual Assault Service submitted by Rowena Chapman (6 pages)
- Gold Coast Centre Against Sexual Violence Inc submitted by Di Macleod (5 pages)
- LivingWell Spiritus Kinections submitted by Gary Foster (29 pages)

Phoenix House

Brief Response to the Review of Queensland Health Responses to Adult Victims of Sexual Assault

KPMG, March 2009

Comments on review.

1.0 Overall the review did not present a gendered analysis of sexual violence, and indeed showed a gendered bias towards males who had been sexually assaulted within the review. Throughout the review men's needs were positioned above those of other groups with specific needs, such as Aboriginal women and children (page 37).

2.0 At no point were the true key stakeholders – the women who access such services - consulted.

3.0 All sexual assault services within Queensland provide a response to adult women (aged 15 years onwards) who have been recently sexually assaulted, which differs from the KPMG reviews statement (page 6 and 66).

4.0 Bundaberg region has a coordinated response providing 24 hour crisis support through the sexual assault service, a dedicated group of local General Practitioners, and the Bundaberg Police. The last local training provided by CFMU was in April 2009. Within this response there are defined entry points and pathways for people who have been recently sexually assaulted.

5.0 Sexual Assault Services in Queensland follow the recommendations of the National Standards of Services Against Sexual Violence, 1998, which provides clear practice standards, which differs from the assessment of KPMG that no evidence is in place to demonstrate that responses are based upon clear and unambiguous practice standards.

6.0 KPMG criticises the lack of response by services to specific groups eg., men, Aboriginal and Torres Strait Islander communities etc.. Bundaberg region provides an inclusive service for all ages, gender and cultures, for example, employs an Aboriginal and Torres Strait Islander support worker, and has a CALD project officer.

7.0 The review lacks consultation as to the best response for Indigenous Australians; there is no mention of the impact of colonisation, and if an Indigenous person's experience of the 'hub' model might be experienced negatively. Have 'hubs' increased the number of reports/prosecutions for this population?

8.0 The review emphasised a higher reported rate of using "one stop location" policy in other areas, however, no actual statistic was presented to support this summary. Examples of the "one stop location" are mainly from metropolitan or highly populated areas which may be not applicable in rural/remote regions of Queensland.

Enhancing Responses

1.0 There is no doubt that Sexual Violence should be afforded a whole of government response and associated policy and practice.

2.0 Service Standards for Queensland Sexual Assault Services *were* developed, by a working party comprising service providers and PVAWP staff in September 1996. There were eight non - Government organisation members, three of whom are still working within the sector (Dianne McCleod, Kathy Prentice and Karin Cheyne). The draft standards were circulated in September 1998, however, Queensland Health decided to adopt the National Standards published by NASASV in 1998. It would be timely to explore these standards again.

3.0 Similarly, in 1995, accredited training commenced for sexual assault workers in Queensland, but this was not progressed beyond the initial year; the training package that has been developed by ECAV *must be consistently* provided to all current workers within the sector, and be made available thereafter for new workers. All workers should have tertiary qualifications and be acknowledged and paid accordingly.

4.0 Sexual Assault Services require enhanced funding in order for them to meet the needs of specific groups, such as Indigenous women, and women in rural and remote areas

5.0 The 1800 crisis line should become a 24 hour service which links into all the other Sexual Assault Services for on-call responses; all Sexual Assault Services require adequate funding to enable them to provide a 24 hour crisis response.

6.0 All women should be afforded the right to a forensic examination, without the need at that time to make an associated formal complaint.

7.0 Memorandum's Of Understanding, (or policy and procedures/directives), need to be urgently implemented between the relevant services to ensure consistency in response and quality of service provision for those people who have been recently sexually assaulted. MOU's should be developed locally between SAS, Health and Police.

8.0 Sexual Assault Services require improved coordination across the State, with stronger links between individual services. This should be facilitated by Queensland Health again through adequate funding.

9.0 Sexual Assault Services should cater for the needs of all of society, and this should be managed accordingly, ensuring women only spaces still remain.

10.0 A key role that Sexual Assault Services play is in the prevention of sexual violence. These responses are now based on the best practice standards developed by Moira Carmody et al, 2009 – National Standards for the Primary Prevention of Sexual Assault Through Education.

11.0 Most critically, as research also demonstrates, sexual assault services should remain trauma-specific services that are designed to treat the actual consequences of sexual trauma, using a non-medicalised model, based on a relational approach and the empowerment of the survivor.

Kathy Prentice,

Director of Services,

November 2009.

Tableland Sexual Assault Service

Reviewing the Review

Notes on the Review of Queensland Health responses to adult victims of sexual assault conducted by KPMG 2009, by the Management and staff of Tablelands Sexual Assault Service (submitted by Rowena Chapman.

Acute or crisis care.

Page 1.

Response to victims: Caution and reference to literature regarding the fact that counselling or debriefing occurring close on the heels of trauma (debriefing) is counter-productive and may in fact exacerbate PTSD. Support however needs to be offered as soon as possible.

Service delivery requirements.

Page 3

Limiting therapies used in counselling provided for people who have experienced sexual assault.

We feel too much emphasis is being put on the types of therapies counsellors will be allowed to use. Studies have shown that the type of therapy used contributes only 10% to the success of counselling that the other 90% is accounted for in the counselling or therapeutic relationship and other factors including supportive relationships, physical needs being met and a sense of safety.

CBT is the most researched therapy, this is research and there is a lack of proof of effectiveness in actual practical and clinical situations. Much of the research being done involves eliminating the types of clients we see from these studies. The fact that CBT is the most researched therapy can also give the illusion that it is the most effective because when a search is done for therapies and trauma CBT studies are over represented in the results. Therapies such as Narrative therapy do not by their nature lend themselves to such research but there is much anecdotal evidence that this therapy is as effective if not more so than other therapies. Many research projects into what therapies work in trauma conclude that no particular therapy stands out in effectiveness rather that any of the mainstream therapies appear to assist clients. Literature shows a high drop-out rate in clients (up to 41%) taking part in CBT studies.

The introduction of one or two compulsory types of therapy for use in sexual assault counselling denies the individuality of clients and counsellors, short term therapies deny the necessity for the building of trust in the counselling relationship so necessary to successful counselling particularly in historical trauma. It also introduces that damaging ‘one size fits all’ concept.

Literature also shows that CBT is not an appropriate therapy for indigenous people and it encourages the use a narrative therapy.

We also express concerns around prolonged exposure therapy, none of the therapists employed here would consider using this particular therapy as there is literature that expresses concern that this type of therapy re-traumatises clients.

(I can reference these statements if you wish but I will need time).

Page 4

Particularly endorse: Responses to be available to all Queensland 24hrs a day

We would also like to raise the issue of School Policies and the lack of coordination of care for school children. Changes to Education Queensland policies around reporting child abuse have resulted in fewer children in this geographic area seeking support from schools and seeking counselling referral from teachers and other Ed Qld employees. Experience shows us that children who reveal sexual assault to Ed Qld employees are immediately referred to Child Safety or Police. If the abuse has occurred outside the family child safety is not interested and they are referred on to the police. If the abuse is historical and the child considered safe neither Dept Child Safety nor the police are interested. In most cases the child then has not counselling as no referrals are made to counselling agencies by police, Ed Qld or child safety. Ed Qld will not refer the child to counselling or allow counselling to occur in school hours without the parents' permission. Since the change in policy we see far fewer children (15 and over).

Consequently we would like to see Education Queensland and possibly Child Safety involved in protocols around responses to sexual assault for 15 yrs and up.

Page 5. (P72,)

Our concern about redistributing funds to Health Service Districts is that funds that are currently being used 'on the ground' in direct service provision would be reduced or restricted and diverted to government meetings and internal Health Service bureaucracy.

Next steps

Page 13

Undertaking of an assessment of service needs and gathering evidence to determine the number and type of services required in each Health District needs to involve both current service providers and clients. This would not work if say Cairns and Hinterland Health Service District decided on a model that suited people living in Cairns and tried to impose that on people living in Ravenshoe or Mt Garnett. The health districts do not have the knowledge we have around issues for clients in accessing appropriate service. Access to counselling services is the major obstacle to receiving counselling in this geographic area.

We have concerns if sexual assault hubs are instigated before they can be properly staffed i.e. with trained nursing staff and forensic examiners be they Drs or nurses. If they are instigated before these staff are trained and available what will happen is simply that the counselling services will attend the HUB with no other activity other than counselling occurring. Establishing a hub which provides only counselling would involve moving and restructuring current counselling services and would seem a waste of resources if the current local service is operating effectively. Our local hospitals to the best of our knowledge do not have spare rooms to offer for counselling. There is also a question around the already existing problems attracting and retaining nurses in rural areas. We would also like to highlight the fact that moving from NGO's providing services to government employees providing

service will involve either a substantial increase in the wages bill for sexual assault or in the reduction of counselling hours available.

Contracting to Indigenous Organisations in this geographical area could be difficult as many indigenous clients state they would not attend our services if we had indigenous workers. Privacy issues are cited as the problem attending indigenous services or services that have indigenous workers.

Will hubs have true accessibility? In order to provide accessibility to our clients we will travel up to 90 minutes to see a client weekly, we are able to see clients in their homes, schools and centres anywhere on the Tablelands within 90 mins drive from our office. In fact in 08/09 31% of clients were seen at our office (some of these have no transport are picked up by staff and brought to the office). The other 69% would not have been able to access sexual assault counselling if we did not offer this outreach. In 09/10 to date the percentages are the same.

Issues around privacy in rural areas are also of concern in a 'Hub' situation. Would clients access counselling services in hospitals? We think it would be helpful to ask current clients this question. Maintaining client confidentiality and privacy is quite difficult to manage in rural areas and in order to do our best to maintain this we stagger appointment times at the office, drive unmarked cars and do not wear identification, our office is an ordinary unmarked house in an ordinary street and we do not publish our address.

Effective criminal justice response

Page 29 (also p 57,)

The establishment of interagency/cross departmental working party to assess desirable improvements to sexual offence training accessed by police - the working party would need to include people who work on the ground, nurses, police and counsellors. They would also need to take into account the uniqueness of the rural environment.

Victims in rural/remote areas.

Page 41

We endorse the comment regarding the main issues specific to rural sexual assault services regarding costing more to provide and the complex practice relationships, however we would like to have the privacy issues and access issues faced by victims to be considered as more important.

Issues

Page 53

We endorse the opportunity for change: provides contemporary responses to all victims of sexual assault (men, women and children). We however acknowledge the need for specific services with feminist based philosophy.

Qld Police service

P 56

In most cases a flyer or card is given to the victim which we know is an ineffective strategy on its own and does not result in these victims accessing support services.

Variation in service provision.

P 63

Services are not provided with any feedback from Qld Health – we believe this is a very important issue. In the two and a half years I have been with this service we have received feedback only once and that was with regard to the way the report was written not with regard to how we were providing services.

Client group

P67

'Sexual assault services consulted generally identified that there is a need to establish a separate pathway for male victims of sexual assault.' I can see that many organisations would indicate this, however we would like it noted that like us not all current sexual assault services would agree with this.

Needs assessment and service planning

P 79

Determining need for sexual assault services on a location by location basis according to population and community characteristics needs to be done with in conjunction with sexual assault service providers in these locations. They have the hands on knowledge and experience of the difficulties in offering access to clients in their particular location.

Quality processes

P81

We strongly agree that current data collection mechanisms neither reflect instance of sexual assault nor the responses provided. We already collect more extensive data in order to inform our own service provision. We also strongly endorse the use of this data in determining services to be provided and for the data to fed back to services.

Practice approaches

P 84

We strongly agree that forensic evidence should be able to be collected and stored appropriately while the client takes time to consider his or her options.

Workforce development

P 85

We would like to request some caution in the effectiveness of standard systems that are not flexible and adaptable to different situations both individual and geographical.

P86

Will people who have a lead role in central office/universities etc have had hands on experience with sexual assault that can match government processes and university research to the reality of providing services on the ground?

We would also reiterate a previous statement around a greater and broader inspection of the therapies that work with sexual assault and trauma. In the academic therapeutic field this is as a

contentious issue as it is in actual practice. We would request that people who actually provide the counselling in existing services be consulted as to what they find works best.

Practice leadership

P 87

We would like to register our doubts that the need for short, medium or long term interventions can be assessed on initial assessment.

Survivor response

P 93

We would like it noted that there does not seem to be an entry point for people wishing to self refer for historical abuse.

Of some concern – the review does not put much focus on community education and who would carry out community education!

We would also like to note that in the 08/09 year 41% of our clients have experienced recent sexual assault, 61% historical sexual assault and 19% have experienced both.

Gold Coast Centre Against Sexual Violence (GCCASV) Inc.

Initial Response to the KPMG Review

Contact: **Di Macleod Director**

Tel: **55911164**

Email: **di.gcsass@bigpond.com.au**

Date: **11 November 2009**

Introduction

Gold Coast Centre Against Sexual Violence Inc. welcomes the opportunity to respond to the KPMG review and to contribute to the Spall Watters Group consultation, by putting forward some initial ideas about improving responses in the Gold Coast region. This information has been compiled with the recognition that there will be other forums to give feedback and contribute to developing sustainable and effective solutions in responding to adult victims of sexual violence in Queensland. A formal response from Gold Coast Centre Against Sexual Violence Inc. will be forwarded to the Health Minister in the new year.

History

For almost twenty years Gold Coast Centre Against Sexual Violence Inc. (formerly Sexual Assault Support Service) has provided accessible high quality counselling and support services to a diverse range of victim/survivors of sexual violence, training to other professionals and innovative prevention programs to the broader Gold Coast community.

Gold Coast Centre Against Sexual Violence Inc. (GCCASV) opened in the Gold Coast hospital in 1990 funded jointly by Family Services and Queensland Health and provided counselling to both adult men and women. In 1991, Women's Health Policy Unit through the Sexual Assault Program became the primary funding source and the target group was defined as women only.

In 1992, GCCASV moved out of the hospital into free accommodation provided by Dept Housing as feedback form service users was that the hospital location inhibited access by adult survivors of SA.

In 1997 GCCASV was provided with $30,000 funding to move into a leased commercial space in Southport.

Apart from CPI increases, there has been no significant increase in funding for sexual violence services since 1997.

In 2006 GCCASV was granted $3.5 million by Queensland Health to purchase or to purpose build a community based sexual assault centre. This project is underway and due for completion in 2010.

GCCASV has operated for almost 20 years and has received award recognition at a local, state, national and international level for its innovative programs and resources. During this time only 2 persons have made a complaint about the service and both were satisfactorily resolved.

GCCASV RESPONSE TO THE KPMG REPORT

Background

GCCASV supports best practice and continuous quality improvement in responding to victim/survivors of sexual violence.

Over time, there has been no leadership from Queensland Health in the area of sexual violence, even in the Queensland Health Strategic Plan 2007 -2012 there is no mention of sexual abuse, violence, assault, or rape.

With no leadership and or cross government approach, it has meant that under-funded individual sexual violence services have had to try and build linkages and collaborative approaches from the bottom up which has contributed to inconsistencies in service development across the state. GCCASV has been very successful at building partnerships, forging memorandums and developing protocols at a local Gold Coast level.

In good faith, agency staff and management in July/August 2008 met with KPMG review staff, attended a broader stakeholder meeting and made a written submission to the KPMG review.

Despite full involvement in the consultation, the outcome of the review was withheld and GCCASV had to resort to an RTI process to access the document which was subsequently uploaded to the Queensland Health website.

GCCASV will prepare a formal written response to Queensland Health concerning the KPMG review, but at this point offers some initial comments.

Initial response - general comments

There are parts of the report that GCGCASV supports:

- Victim choice for immediate forensic collection with delayed release to the police in order to make an informed decision at a time post initial shock and crisis. Gold Coast police are also in favour of this option as research shows that victims are three times more likely to report to police when forensics are collected (KPMG, p.44)

- Funding for men needs to be given consideration even though the number of males raped as adults is small, the number of male adult survivors of child sexual assault is more significant. Research shows that 1 in 20 adult men experience sexual coercion (de Visser, Smith, Rissel, Richters & Grulich, 2003 cited in Astbury 2006) and 1 in 6 men reported having unwanted sexual experiences in childhood (Najman, Dunne, Purdie, Boyle & Coxeter, 2005 – cited in Astbury, 2006)

There are areas that are refuted:

- The development of a hub within ED. This is not a suitable environment for ongoing therapeutic work for either recent victim follow up nor for adult survivors. Crisis care in hospital and follow up in the community is the logical development and best practice in Victoria, New Zealand and USA.

- In fact, there is no evidence on the appropriateness of simply co-locating police, legal, support and medical services in one facility. Models of care must be victim/survivor-centred, evidence based and appropriate for the settings in which they are provided (Keesbury & Askew, 2009).

- The report makes a number of generalizations including that NGO's only see adult survivors and not recent rape victims. Gold Coast statistics from the last financial year show that the agency responded to 728 female victim/survivors of sexual violence, the presenting issue for 63% was sexual violence experienced as an adult, for 26% the presenting issue was child sexual assault and for 11% the presenting issue was multiple assaults. 13% sought support within one week of the assault and another 32% sought support within 52 weeks (GCCASV, 2009)

- The assumption that NGO's have made their own decisions not to see men when the target group is dictated by funding agreements and no funding has ever been provided by Queensland Health to provide counselling services to males.

- Errors in the citation of incorrect and misleading data e.g. on page 37 of the KPMG report it states that 17% of men have been assaulted at least once since they were 15. However, the research actually states 17% of women and 4.8% of men had been assaulted since 15 (ABS, 2005:7).

- There is no recognition of supporting significant others nor the importance of balancing sexual violence prevention education with intervention work. No acknowledgement of the great work currently done by NGO's. GCCASV has numerous awards in the prevention area.

Cautions

These issues must be taken into account when considering any of the recommendations of the KPMG report:

- That any changes to the distribution of SASPP funding recognise the myriad of skills, experience and best practice approaches currently existing within the Queensland sexual violence sector.

- That despite the lack of specific counselling services for male sexual violence victim/survivors, funding integrity must remain paramount. It is crucial that designated women's health funds for sexual assault counselling are not sidetracked into providing services for men. It must be remembered that as well as being a minority group of victims of sexual violence, males are also the majority of offenders (Griffiths, 2003). Therefore the majority of this funding should be for prevention.

- The KPMG report emphasizes best practice, however, it is important to differentiate and recognise that best practice in system design and management does NOT necessarily mean best practice in responding to victims.

INITIAL SUGGESTIONS FOR A WAY FORWARD ON THE GOLD COAST

Queensland Health cannot continue to fund SA in an ineffective and unsustainable way as this ultimately impacts service delivery at the coalface. Services have had a six month funding reprieve and now a 12 months funding reprieve but this limits expansion of existing programs and development of new programs. It is an untenable situation for workers who have no job security. Minimum three year funding cycles are essential for forward planning and sustainability.

Appropriate funding for a 24 hour acute response to adult victims of recent sexual assault

Agree with the report that the site for the crisis care response is best placed within a primary health facility close to the Emergency Department.

- That there be funding for specialist sexual violence workers to support victims

- That the FMO routinely conducts forensic medicals and arranges storage so that the decision to report to police can be delayed by the victim
- That the justice response is integrated whereby Police are called to attend the crisis care unit when specifically requested by the victim

Appropriate funding for adult victims of recent as well as past sexual violence

The need to look beyond crisis care and develop a community based hub

- The site for this response to be at the purpose built hub currently being developed by GCCASV.
- Additional funding for GCCASV to provide adequately resourced, safe, ethical, professional services for women and young women.
- Funding for a GP with interest in sexual assault and resulting sexual health issues for follow up medical/health issues

Access to forensic medical examinations

That the current Interagency guidelines are met which give victims a chance to delay reporting to the police and make an informed decision at a later time

- That FMO's conduct "just in case forensics" as in other jurisdictions.
- That forensic examinations are performed, forensic material securely stored and release to police delayed to allow the victim more time to make a decision.
- The provision of this option allows the medical system to contribute positively to justice seeking for victim/survivors of sexual violence (Jewkes et al., 2009)

Funding for men

- Additional funding to GCCASV to develop safe ethical professional services for men and young men**.**
- That this funding is provided equitably to reflect the comparative prevalence of sexual assault between genders.
- The response to be developed based on the identified needs of Gold Coast men who have experienced sexual violence site to be determined with consideration given to the identified best practice SAMSSA Model auspiced by the Canberra Rape Crisis Centre (Crome, 2006)

References

Astbury, J. (2006). Services for victims/survivors of sexual assault – Identifying needs, interventions and provision of services in Australia. Issues Paper no. 6, Australian Centre for the Study of Sexual Assault, Canberra.

Australian Bureau of Statistics. (2005). Crime and Safety, Australia. Australian Bureau of Statistics, Canberra.

Crome, S (2006) Male survivors of sexual assault and rape in ACSSA Wrap No.2, September 2006, Melbourne

Gold Coast Centre Against Sexual Violence Inc. (2009) Annual Report 01 July 2008 – 30 June 2009, Gold Coast Centre Against Sexual Violence Inc., Gold Coast.

Griffiths, M (2003, February). There is a guy on the phone, he reckons that he's been raped. Practice and Prevention: Contemporary issues in adult sexual assault in NSW conference, Sydney.

Jewkes, R., Christofides, N., Vetten, L., Jina, R., Sigsworth, R., Loots, L. (2009) Medico-legal findings, case progression and legal outcomes in South African rape cases: A cross-sectional study, South African Medical Research Council, South Africa

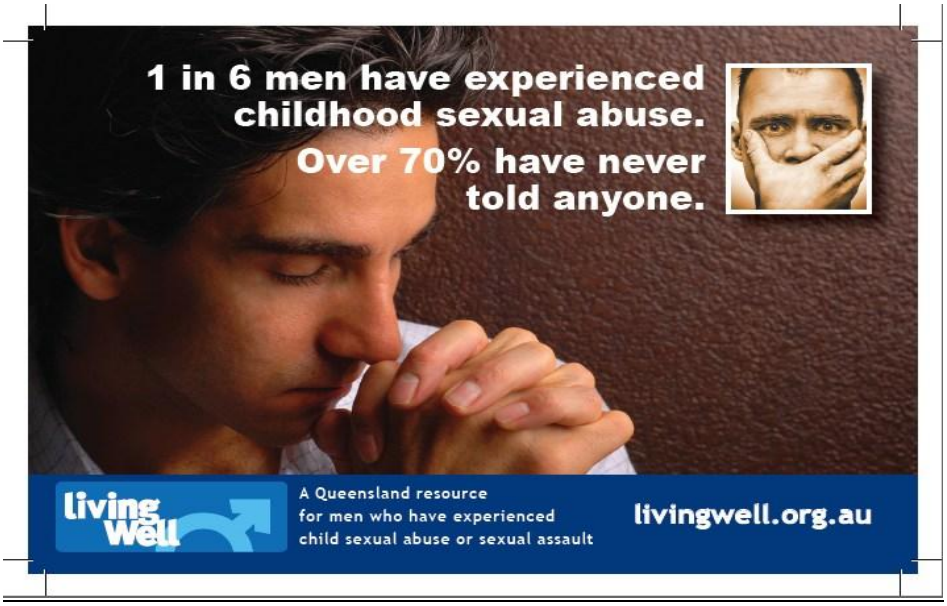
Keesbury, J & Askew, I, (2009) Lessons Learned In Providing SGBV Services In Africa - A Review Of Emerging Evidence, Population Council, South Africa

KPMG, (2009) Review of Queensland Health responses to adult victims of sexual assault, KPMG, Sydney

NASASV (National Association of Services Against Sexual Violence). (1998). National Standards of Practice Manual for services against sexual violence. CASA House, Victoria.

Queensland Government (2007) Queensland Health Strategic Plan 2007-2012, Queensland Government, Brisbane.

LivingWell Spiritus Kinections



LivingWell's Initial Response to the KPMG

Review of Queensland Health

responses to adult victims of

sexual assault.

LivingWell

Spiritus Kinections

Unit 9/1220 Sandgate Rd,

Nundah, Q 4012

Ph (07) 3435 4358

Fax (07) 3256 7466

Email gfoster@spiritus.org.au

'There are some clear gaps in service delivery:

Services are available to women only and there are no Queensland Health funded service for male victims. This situation is untenable and must be addressed urgently' (KPMG Review 2009:70).

Introduction

LivingWell welcomes the release of the KPMG Review of Queensland Health responses to adult victims of sexual assault, and the subsequent invitation to put forward some initial ideas about improving services. In foregrounding some of the difficulties that adult male victims of sexual assault experience, LivingWell is interested in developing a new way of responding that ensures effective, quality, evidence based, victim centred services throughout Queensland. It welcomes the KPMG Review's emphasis on developing a fully integrated service system that includes whole of government policy development, with a focus on prevention and integrated health and criminal justice responses. LivingWell welcomes governance arrangements that support integration across government departments, at a service delivery and at a program level, with a focus on quality management that comprises continuous improvement, professional development and joint training opportunities.

Our position

LivingWell is a service that is designed specifically to assist men who have experienced childhood sexual abuse or sexual assault, their partners, friends, families and service providers. We offer face to face individual, couple and family counselling, telephone and email counselling, group support, individual support in contacting police and negotiating the criminal justice process, comprehensive information via the www.livingwell.org.au web resource, and professional training and consultation to service providers. LivingWell is currently supported by a grant from the Anglican Church Community Service Commission through Spiritus, and operates alongside Spiritus Kinections counselling and education services in South East Queensland.

This initial response by LivingWell to the KPMG Review of Queensland Health services to adult victims of sexual assault is tendered as part of the 'Review of the Review' consultation process initiated by Queensland Health in November 2009. Whilst highlighting here some particularly pertinent issues for adult male victims, it is not the intention to comment on all aspects of the review. The 'Review of the Review' presented in this document is therefore limited and is put forward with the understanding that there will be future opportunities to contribute to the development of improved services for all victims of sexual assault throughout Queensland.

Need to develop appropriate victim centred service responses

The KPMG Review is to be commended for its emphasis on the development of victim centred service delivery. It advocates that "all components of the response must be victim centred and allow victims to control the pace, nature and direction of the response" (2009:49). In discerning what it means to be 'victim centred', the KPMG Review identifies a need to design a service that responds to the particular needs of both 'victims' of recent sexual assault, and 'survivors' of historical sexual abuse. It also identifies an organisational responsibility to be aware of and to plan around the barriers faced by particular 'victim sub groups' i.e. male victims, Indigenous victims, victims from culturally and linguistically diverse backgrounds, gay, lesbian, bisexual and transgender people,

rural and remote victims, victims with a disability, victims with a mental illness and institutional victims. LivingWell supports this commitment to victim centred service, designed to respond to the particularity of experience and the need of diverse groups of 'victims' and 'survivors' of sexual assault. The challenge for Queensland Health is in enacting a truly victim centred approach in all its complexity.

Fully integrated and coordinated service delivery throughout Queensland.

In seeking to develop a fully integrated victim centred response that ensures best practice in relation to the coordination of medical, forensic, police, counselling and support responses, the KPMG Review has proposed the implementation of sexual assault hubs within each Health Service District. Whilst it is clear that current best practice identifies a need for quality service provision that ensures synergy between forensic and medical responses, police/criminal justice systems and counselling/support, the hybrid 'co-located' model being proposed by the KPMG Review is only one possible hub model. In considering a way forward, it is important to note that the evidence that the KPMG Review calls upon to advocate the proposed 'one stop shop' is drawn from a review of the UK Sexual Assault Referral Centres (SARCs).[8]

The SARC services have been fully evaluated, and have been found to be effective in enhancing the medical and forensic responses and early complaints to police. However the SARC model of service delivery is primarily focussed on responding to recent sexual assault. The National Service Guidelines for Developing Sexual Assault Referral Centres identifies a need to "refer patients on to other services for:

- Hospital services for treatment of injuries
- GUM services for ongoing sexual health needs
- Victim Support, for information on police and court procedures, advice on claiming compensation and advocacy services where these are not available through the SARC
- Specialist rape crisis and other sexual violence organisations where clients:
  - have a preference for counselling/advocacy away from the centre;
  - have a preference for counselling in a women-only environment;
  - need long-term counselling; or
  - are victims of historical rather than recent sexual violence, including adult survivors of childhood sexual abuse."[9]

The SARCs model of service delivery clearly identifies best practice processes and protocols that can be drawn upon, and developed, to create an integrated and coordinated response to victims of recent sexual assault in Queensland. In advocating for

[8] Lovett, J. Regan, L. & Kelly, L. Sexual Assault Referral Centres: developing good practice and maximising potential, Home Office, London: 2004.

[9] UK Home Office. 'National Service Guidelines for Developing Sexual Assault Referral Centres (SARCs)'. Home Office, London: 2005: 25- 26.

the 'co-located' SARC style model there is however, a danger that 'co-located' becomes understood as the only possible representation of integrated and coordinated service delivery, when alternative models are available.

The Victorian model of service delivery is another model that prioritises the development of a fully integrated and coordinated response. The Centres Against Sexual Assault (CASA) respond to both victims of recent sexual assault and survivors of historical abuse. As the KPMG Review highlights, the Victorian Sexual Assault Reform Strategy prioritises integrated governance mechanisms, ensuring cross government collaboration at a department level, a service delivery level, and a program level. To assist in this process the Victorian CASAs are guided by Standards of Practice that require continuity of service delivery throughout the state. The CASA's operate a model where the forensic and medical responses can be located at one site, and the follow up counselling and support at another. The value of locating some aspects of the response to recent assault within hospital settings is that care and support, medical, forensic and police service, are able to be delivered in a timely and integrated manner. The value of a community based service is, that counselling and support can be tailored to respond to the particular needs of the diverse group of clients, be they victims of recent assault, or survivors of historical abuse. In Victoria the different aspects of the service responses are able to ensure continuity of care and support, and be fully coordinated and integrated without necessarily operating from the same site.

Although, within Victoria there is a history of services being provided within government departments, there appears no reason why victim centred services cannot be outsourced to lead community based agencies, with appropriate governance mechanisms in operation to ensure continuity of service provision throughout the state. In fact, the KPMG Review signals the value of lead community based agencies in responding to the needs of victims and survivors of sexual assault, in particular Indigenous people, and people from Culturally and Linguistically Diverse communities (2009:96).[10]


A challenge for Queensland Health is to design a best practice response that ensures quality of service delivery throughout diverse Health Service Districts. It may be that a fully integrated and coordinated model that draws on the best of the initial medico-forensic response model, and the community based model will provide a way forward.


Since the completion of the KPMG Review, Victims Assist Queensland has been established within the Department of Justice and Attorney General and a new model of service provision to victims of crime introduced. How the Queensland Health funded services will work in a coordinated way with VAQ In developing a whole of government integrated service response is unclear?

Gender

Presentation of concerns and identification of the salient issues for service responses to men who have experienced childhood sexual abuse or sexual assault, is undertaken here

[10] It is difficult to provide a comprehensive response to the KPMG Review in relation to the suggested 'new way of responding', without access to the Review of Queensland Clinical Forensic Medical Unit services.

with an appreciation of the importance of operating with a 'gender analysis'. The fact that sexual assault is a 'gendered crime', is emphasised in the KPMG Review 'While any Australian can become a victim of sexual assault, the vast majority of those who report an incident are female, and the overwhelming majority of perpetrators are male' (2009:15). In acknowledging that sexual assault is a gendered crime where women are predominantly the subjects of men's sexual violence, this does not preclude recognition that 1 in 6 men are also subjected to sexual violence (predominantly by men). In developing a 'victim centred service', it is important to recognise that gender as a social determinant not only influences who sexually assault's whom, it is also shaping of people's experiences of sexual assault, how they understand what happened, their subsequent responses, the support available to them, and the types of assistance that is appropriate. Recent research has emphasised the:

> *'importance of thinking about the role gender plays in the lives of sexual abuse survivors: it must not be conflated with sex and treated simply as a variable that may predict exposure to particular types of trauma or needs to be 'controlled for' in statistical analysis. It must be understood as a social construct that influences the way survivors make meaning of their experiences'.*[11]

Given the role of gender in mediating health outcomes, it becomes necessary to design a service delivery model that is able to respond to the gender specific needs of women, men and transgender people.


It is unclear from the KPMG Review how the gender specific needs of women, men and transgender people will be identified and responded to through service delivery?

Service design that responds to both men's and women's experiences

In looking to develop a quality service that appropriately assists people who have been sexually victimised, it is important to maintain an awareness of the similarities and differences amongst men and women in the experience of sexual assault, as well as the impact and suitability of service responses. A UK report highlighting *The inter-relatedness of sexual victimisation and priority social and health policy* produced a comprehensive, but by no means exhaustive list, of social and health effects of sexual victimisation reported by both men and women:

> *'…post traumatic stress symptoms; depression; anxiety; dissociation; sleep problems; flashbacks; nightmares; anger; low self esteem; lack of confidence; self harming behaviours; suicide; alcohol and drug misuse; work-holism; prostitution; criminal activity (including - for a small minority - sexual offending) ; homelessness; revictimisation; parenting and relationship difficulties; eating issues; lack of trust; sexual difficulties; confusion of sexuality; chronic physical pain and mental health problems; transient psychotic episodes; borderline personality disorder; dissociative identity disorder and somatisation.*[12]

[11] Grossman, F.K., Sorosli, L. & Kia-Keating M. 'I keep that hush hush': Male survivors of sexual abuse and the challenges of disclosure. Journal of counselling psychology Vol. 55, No 3 333-345 (2008).

[12] Survivors Trust, UK "The inter-relatedness of sexual victimisation and priority social and health policy" 2004

Research suggests that a need to create an environment where men's and women's experience are acknowledged in a way that neither ignores the influence of gender, nor amplifies its significance. As Hooper and Warwick note 'many of the experiences of retraumatization which adult survivor's encounter with services are the result of misrecognition of their experience or needs, and both denial of the relevance of gender and exaggeration (through reliance on stereotypes)".[13] [14] When gender is fore grounded as an influential factor requiring consideration, the specifities of women's, men's and transgender people's experiences of sexual assault becomes acknowledged and more appropriately responded to.

The Problem of under reporting and the barriers to accessing service

'Overall in Australia, rates of reporting to police remain low, with an estimated 80% of sexual assaults still going unreported.' (KPMG 2009:15)

When designing a victim centred response to sexual assault there is a need, as the KPMG Review identifies, to address the significant issue of under reporting of sexual assault, and to design a service response that considers those many victims who do not wish to make a formal report to police. Research indicates that, even taking into consideration the extremely low rate of reporting of sexual offences by women, men are one and a half times less likely than women to report a sexual offence to police.[15] It appears that:

- Between 70-90% of men who have experienced child sexual abuse haven't told anyone.
- In one study of 40 boys who experienced child sexual abuse and attended an adolescent medical facility, none had ever told their primary care giver.
- Men typically disclose childhood sexual abuse or sexual assault 10 years later than women.[16]

A recent Australian study provides some insight into the differences between men and women, in relation to the time taken to disclose sexual assault and the time taken to discuss it.

Disclosure at the time	Men n=122	Women n=151
Disclosed	26.2%	63.8%
No disclosure	73.8%	36.4%
Time taken to discuss	Men n=145	Women n=138

[13] Hooper and Warwick 2006:476 Hooper, C. & Warwick I. 'Gender and the politics of service provision for adults with a history of childhood sexual abuse' in Critical Social Policy Vol 26(2): 2006:473.

[14] When gender has been examined as a factor influencing responses to sexual assault, men appear to exhibit a greater propensity for externalising behaviours and women for internalizing behaviours. Romano, E. and De Luca, R. Male sexual abuse: A review of effects, abuse characteristics, and links with later psychological functioning in Aggression and Violent behaviour, Vol. 6 Issue 1. 2001.

[15] Pino, N. W., & Meier, R. F.'Gender differences in rape reporting.' Sex Roles, 40(11/12), 1999:984

[16] Holmes, W. C. "Sexual abuse of boys: Definition, prevalence, correlates, sequelae and management", Journal of the American Medical Association, Vol. 280, No 21, 1998.

Less than 1 yr	9.7%	14.5%
Less than 10 years	17.2%	36.2%
Less than 20 years	28.3%	23.9%
More than 20 years	44.9%	25.4%[17]

A simple examination of available statistics taken from the Queensland Police Service, Personal Safety Survey and also from international research detailing prevalence rates, gives an indication of the extent of the problem of sexual assault of men in Queensland. It also highlights the extent of the problem of under reporting by men, and the degree of change required in order to ensure a service is available to all victims of sexual assault, and not just those who currently approach services for assistance.

In 2008/09 the Queensland Police Service presented the following statistics in relation to sexual offences :

Queensland Police Service – Reported Sexual Offences 2008/9

• Under 15		15 and over		Total	
• Males	Females	Males	Females	Males	Females
• 442	1736	292	1212	734	3948

When compared with statistics based on the self reporting of experiences of sexual assault in the most recent National Personal Safety Survey, the number of sexual offences reported appears extremely low.

In 2006 the Queensland population of males was recorded at 1,935,400 (413,900 under 15 and 1,521,500 over 15). The 2005 Personal Safety Survey was the first of its kind to ask questions about sexual assault of males, previously questions in relation to sexual assault had only been asked of women through the 'Women's Safety Survey'. The Personal Safety Survey identified that 0.6% of men experienced sexual assault in the year prior, 4.5% reported being sexually assaulted before the age of 15, and 5.5% reported being sexually assaulted at age 15 and over.[18] This translates to:

Personal Safety Survey 2005

- 9,129 Queensland men are sexually assaulted per annum.
- 87,093 Queensland men sexually assaulted prior to 15 years of age
- 106,447 Queensland men sexually assaulted at 15 years of age or over.

In presenting these figures it is recognised that some Queensland men will experience sexual assault as both a child and as an adult. However, international research over the past 20 years has consistently produced figures that suggests 1 in 6 males experience

[17] O'Leary, P., & Gould, N. 'Men who were Sexually Abused in Childhood and Subsequent Suicidal Ideation: Community Comparison Explanations and Practice Implications', Journal of British Social Work, 39, 2009:950-968.

[18] The data that states males are more likely to be assaulted when over 15yrs than under 15yrs is an 'anomaly' in relation to established research knowledge and hence deserves further investigation and explanation.

childhood sexual abuse or sexual assault.[19] In the Queensland context the KPMG noted that this is equivalent to:

> KPMG Review 2009:37
>
> - 362,400 Queensland Men who have experienced childhood sexual abuse or sexual assault.

When seeking to design a service response to all victims of sexual assault, the seriousness and extent of the problem of underreporting needs to be taken into consideration. There is considerable difference between configuring a Queensland Health response to 292 Adult victims who report to police, as opposed to the 362,400 Queensland men who have experienced sexual violence.

 It is unclear when reading the KPMG Review as to what specific strategies might be developed to address the serious problem of under reporting of sexual assault by both males and females, 'victims' and 'survivors'.

In the 2008 'Cry for Help' report into 'client and worker experiences of disclosure and help seeking regarding child sexual abuse', a specific recommendation was made to 'Build the confidence and skills of 'victims' to disclose CSA and seek help, by circulating stories of other survivors (that are tailored to a range of age groups) through, for example, radio, theatre, publications, beer coasters. Given the high incidence of unhelpful responses to disclosures, these stories may include advice on what to do if a disclosure is not met with the response that was hoped or expected.[20]

 A challenge that Queensland Health faces in developing community education campaigns in order to encourage disclosure is that, currently, 19 out of the 28 sexual assault services are not designed or funded to assist men, hence such a campaign is more likely to produce further distress and problems for men.

Barriers to disclosure and accessing services

'Considerable efforts are required in Australia to educate men to come forward after sexual assault and 'more publicity is needed to dispel the myths about male sexual assault' (KPMG 2009:37).

In seeking to respond appropriately to men who have experienced sexual assault, the KPMG review highlights the need to address particular issues and barriers to accessing support and services. Whilst typically, men experience many of the same challenges that women experience in seeking to speak about sexual assault and to access appropriate support, it is recognised that men identify struggles with restrictive gender stereotypes,

[19] Dube, S. R., R. F Anda, C. L Whitfield, D.W. Brown, V. J Felitti, M. Dong, W.D. Giles "Long term consequences of childhood sexual abuse by gender of victim." American Journal of Preventative Medicine 2005; 28(5).

[20] Breckenridge J., Cunningham, J. and Jennings K. 'Cry for help: Client and worker experiences of disclosure and help seeking regarding child sexual abuse'. Australian Institute of Social Relations and The University of New South Wales, 2008.

homophobia, victim to perpetrator discourse and lack of developed services (KPMG 2009:37).

Dominant Masculinity

Dominant stereotypes of masculinity that suggest that boys and men should be strong and able to defend themselves, even against overwhelming odds, make it difficult for men to talk about sexual abuse or assault. O'Leary notes that 'dissonance between male role expectation and the experience of 'victimisation' impacts significantly on men's experiences and can have men questioning their whole gender identity.[21] Men who have been sexually assaulted report difficulties with limited stereotypical ideals of manhood that portrays men as:

- Strong and powerful – physically and mentally
- Not showing emotions - emotions being seen as 'female'/feminine
- Instinctual/biological masculinity - intrinsically male – not trying, just are
- Self-reliant ("stand on you own two feet", "big boys don't cry")
- In control - of self, environs, & others
- Heterosexual – the doers and instigators of sexual acts
- Not victims

Limited ideals of manhood can compound problems for men, in that men are often down on themselves for not stopping the assault from happening and for struggling with the aftermath, because 'as men they should be able to cope'. This sense of 'failure as a man' make it less likely for men to speak about the sexual assault and seek help, leading to increased isolation and its accompanying problems.[22]

Homophobia

Homophobia and confusion regarding sexuality can inhibit men speaking about sexual assault. If a man was sexually assaulted by a man he may be concerned that people will think he is gay, and discriminate against him, or if he was abused by a woman that people will not take his complaints seriously, and think he should be okay about it. Personal concerns with questions of sexuality often trouble men even if they have never previously experienced sexual interest in another man. The fact is that homophobia, personal and public, acts as a major inhibitor of men disclosing abuse and seeking any form of assistance.

 Although the KPMG Review identified that '[b]eing a victim of sexual assault can be a challenge to common masculine stereotypes of men being able to protect themselves, and this can create difficulties for males expressing weakness or vulnerability and seeking support', and that 'particularly relevant to males are sexual orientation conflict,

[21] O'Leary, P.J. 'Working with male victims of childhood sexual abuse', Chapter 8 In B. Pease & P. Camilleri (eds) Working with Men in Human Services, Allen and Unwin, Melbourne: 2001

[22] Lisak, D. 'Male survivors of trauma. In G.E. Good & G.R. Brooks (Eds) The new book of psychotherapy and counselling with men: A comprehensive guide to settings, problems and treatment approaches (Rev & abridged ed. 147-158) San Francisco: Jossey Bass: 2005.

homophobia, male specific sexual dysfunction and compulsion'(KPMG 2009:37). It is unclear how these barriers to reporting and accessing services are to be addressed?

Victim to perpetrator discourse

Not mentioned in the KPMG Review, but a significant barrier to men accessing services is the suggestion that a man who experiences abuse is likely to go on to perpetrate abuse. Concern that as a 'victim' a man will become a 'perpetrator' of abuse is disturbing to men. It stops men from speaking about abuse out of fear of how they will subsequently be perceived or treated. Unfortunately the 'automatic' route from victim to perpetrator is often reproduced in the media and government documents. A particularly telling example is the opening vignette from *Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred"* Report.

> "HG was born in a remote Barkly community in 1960. In 1972, he was twice anally raped by an older Aboriginal man. He didn't report it because of shame and embarrassment. He never told anyone about it until 2006 when he was seeking release from prison where he had been confined for many years as a dangerous sex offender. In 1980 and 1990, he had attempted to have sex with young girls. In 1993, he anally raped a 10 year old girl and, in 1997, an eight year old boy (ZH). In 2004, ZH anally raped a five year old boy in the same community. That little boy complained "ZH fucked me". Who will ensure that in years to come that little boy will not himself become an offender?"

Although, it is important to intervene where abuse is occurring it is also important to be aware that research has found that 'most male victims of child sexual abuse do not become paedophiles, but particular experiences and patterns of childhood behaviour additional to sexual abuse are associated with an increased risk of victims becoming abusers in later life'.[23]


In developing a service response to men it is important to address uncritical acceptance and promotion of victim to offender discourse, whilst at the same time ensuring that service responses are in place that address all offending behaviour. It is unclear how, in the articulated co-located service hub model, this barrier to disclosure and accessing support will be addressed at a state wide and local level.

Lack of services to men as a barrier to gaining assistance

'Some evidence suggests that when men do seek help they may be treated poorly, creating 'secondary victimisation' or 'sanctuary trauma' through a lack of empathy and understanding of the effect of rape on the victim'(KPMG 2009:37).

The KPMG review highlights that the current lack of visible support for men who have experienced sexual abuse or sexual assault, not only stops men from speaking about what was done, but can actually compound problems. This issue is particularly pertinent in

[23] D.Salter, D.McMillan, M.Richards, T.Talbot, J.Hodges, A.Bentovim, R.Hastings, J.Stevenson, D.Skuse. "Development of sexually abusive behaviour in sexually victimised males: a longitudinal study'. The Lancet, Volume 361, Issue 9356, 2003:471-476.

designing a way forward for Queensland Health given non-government sexual assault service funding is currently directed to provide women only services. [24] [25] Adding to the difficulties is the fact that in the sexual assault field, it is an unfortunate reality that 'compared with females, recognition of male victims is seen as a relatively new discovery, and attitudes to service delivery needs and other responses can be uninformed and indifferent'.[26]

Although the KPMG Review highlights the lack of current services available for male victims and the negative impact this has, it does not detail how the gender specific needs of men will be addressed in the hub model of service design and delivery.

There is a challenge for Queensland Health in transitioning from a service delivery model designed specifically to address men's violence against women, to a model designed to assist all victims and survivors of sexual assault. Given that current service models have been developed and enhanced in relation to working with women, it may be necessary to devote some dedicated thinking and resources to designing appropriate service models for working with men. When Victorian CASAs commenced provision of services to male clients additional funding was provided to assist with the transition.[27]

Practice standards

In line with best practice the KPMG Review recommends the development of practice standards coupled with appropriate Queensland Health quality assurance monitoring mechanisms (KPMG 2009:81). When developing these standards, there is an opportunity for Queensland Health to draw upon the National Standards of Practice Manual for Services Against Sexual Violence (NSPM,1998) and the 'Standards of Practice for Victorian Centres Against Sexual Assault'(2000). The development of Queensland Standards of Practice for Sexual Assault Services would be an opportunity to address a gap identified within the National Standards of Practice Manual some 11 years ago, that is a "need for more detailed standards for working with male victim/survivors" and that "such standards would need to address some unique issues faced by male victims and the implications for practice" (NSPM, 1998:vii).

[24] In 1996 Denise Donnelly and Stacy Kenyon in an article titled " 'Honey, We Don't Do Men', Gender Stereotypes and the Provision of Services to Sexually Assaulted Men" recognised a systematic failure of criminal justice and sexual assault services to provide assistance to men who have experienced sexual violence. In 1999, Patricia Washington identified the "Second Assault of Male Survivors of Sexual Violence" and provided detailed reports of unhelpful responses from the legal system, counsellors, medical practitioners and police services, and the additional difficulties men in particular can face in accessing sexual assault services, and lack of support from close family and friends. Washington, P. "Second Assault of Male Survivors", Journal of Interpersonal Violence 1999: 713-730.

[25] Hooper and Warwick report that recent research "suggests that women's disclosures of abuse are more likely to lead to a referral to abuse related therapy, than disclosures by men, although again it is not clear whether this is a result of perceptions of need or of availability of services Hooper, C. & Warwick I. 'Gender and the politics of service provision for adults with a history of childhood sexual abuse' in Critical Social Policy Vol 26(2): 2006:473.

[26] Hooper, C. & Warwick I. 'Gender and the politics of service provision for adults with a history of childhood sexual abuse' in Critical Social Policy Vol 26(2): 2006:473.

[27] Victoria CASA Forum Standards of Practice for Victorian Centres Against Sexual; Assault. Victoria, 2000:137

 It is unclear from the KPMG Review whether Queensland practice standards will provide detailed standards for working with male victim/survivors that address gaps identified at both a National and International level.

Victim choice, as to the gender of the practitioner

The KPMG Review advocates a 'victim centred' approach that emphasises 'victims should be able to control the pace of all interventions and make informed decisions about the response should occur" and that "this includes having choice about the sex of the medical examiner" (KPMG 2009:3). It goes on to quote research that found 74.6% of all victims attending an acute medical forensic service indicated a preference for a female counsellor/support worker, and that 'some men feel safer working with women, especially in the context of emotional repression and relationship struggles. Alternatively others need the opportunity to explore issues of sexuality, masculinity/vulnerability and social behaviour with men'.[28] Whilst it is acknowledged that 'preferences are not always predictable, and other factors such as worker's personality, personal experience of abuse, ethnicity or status as a parent may be more important to some people than gender'. It is also recognised that opportunities to choose the providers gender can assist in the 'reparative' process and should be part of any best practice response.[29] Currently, SAMSSA and a number of Victorian Centres Against Sexual Assault operate a best practice model of offering service users choice as to whether they wish to see a male or female counsellor.[30]

 Although offering the victim choice as to the sex of the medical examiner is emphasised in the KPMG Review, it is unclear whether choice as to the gender of the counsellor is to be supported through funding and training?

Emphasis on men friendly services

'Nationally service responses to males are not comprehensive and service access by males is very poor.' (KPMG,2009:37).

The problem of the limited service responses available to men who have been sexually assaulted, and men's reluctance to access support services, is highlighted within the KPMG Review at a time when national attention is focusing on improving men's health strategies, and creating men friendly services. In 2009 the federal government engaged in a process of developing a National Men's Health Policy and produced the *Introduction to working with men and family relationships guide*.

---

[28] Chowdhury-Hawkins, R et al 'Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs)', Journal of Forensic and Legal Medicine, Vol.15, No.6, 2008:363-7.

[29] Hooper, C. & Warwick I. 'Gender and the politics of service provision for adults with a history of childhood sexual abuse' in Critical Social Policy Vol 26(2): 2006:473.

[30] In the Australian Government funded initiative "Introduction to Working with Men and Family Relationships Guide", there is specific guidance and support offered to 'Women working with men', identifying the strengths, challenges and practical aspects of women working with men in particular contexts. The guide also acknowledges that for some men, Indigenous men and men from culturally and linguistically diverse backgrounds it is culturally appropriate that a male counsellor be available.

The National Men's Health Policy Information Paper notes that "The existence of services does not mean that they are being used well, or by those who can substantially benefit" and it recognises that men visit health care professional less than women, and seek help only after a crisis has occurred.[31] The men's health strategy paper highlights the needs for community responses that engage and reach out to men and produce cultural change in men's help seeking. Men who have experienced childhood sexual abuse, like many men, are often not accessing health service until their health has become severely compromised. For example, one man described how:

> *'It was last August when it just went bang! I had sort of handled things up to that stage. I thought things would never change. I must have fucked it up bad. Lost my licence ... because I got pissed and stoned all the time and did whatever I wanted to do ... I went with this chick ... we'd been in the sack together and I had visions of when I was a kid - went back there and it freaked me out. It was after that I got pissed. I was popping Valium two at the time, and ran amuck. Went home on a Saturday and didn't wake up til Monday! My old lady [mum] found me on the floor, and I ended up in hospital for a couple of days. That's when I thought I'd better sort out this shit once and for all.'*[32]

Research with men that have experienced childhood sexual abuse and sexual assault suggests that there is a need to be more proactive:

> *'To be fair, men don't disclose as frequently or as easily as women do…so they [health professionals] aren't going to ask the question. They aren't going to hurt the man's feelings by saying well have you been abused…But I think they need to be better aware of the signs especially in men and to, if necessary, ask the questions".*[33]

In seeking to map a way forward the Men's Health discussion paper emphasises that availability, access and suitability of services, needs to be reviewed and adapted to reach out and fit closely with men's particular values and life practices. The Information paper proposed men's health policies be built around five foundation principles:

1. Gender equity;
2. An action plan to address need across the life course;
3. A focus on prevention;
4. A strong and emerging evidence base; and
5. Needs of specific groups of men most at risk.

In 2009 FAHCSIA released the *Introduction to working with men and family relationships guide* which also identified a number of key principles, this time in relation to developing service responses that engage and work effectively with men.

[31] Nixon, M (Hon) 1999, Report of the Committee Reviewing Family and Parent Support Services for Men. WA. A recent general practice survey found that '…men's consultations tend to be more superficial, shorter, and occur later in the disease process' and that men are reluctant to engage in preventative health consultations (check ups) during their early and middle years; Malcher G, Men's Health, GPs and GP's4Men, Australian Family physician, Vol 34, No ?, Jan/Feb 2005.

[32] O'Leary, P. 'Men were sexually abused as children'. Doctoral Thesis, Flinders University, South Australia 2003.

[33] Teram, et al "Towards malecentric communication: sensitizing health professionals to the realities of male childhood sexual abuse survivors", in Issues in Mental Health Nursing. 27, 2006:499-517.

Eight principles for working effectively with men

1. The importance of perceived equality

A gender equity approach recognises that gender is a social determinant of health, and that men and women are given equal opportunity to maintain and enhance their health (WHO, 2001 'Madrid Statement'). A gender equity approach recognises the different challenges that face men and women in managing their health, including their different health requirements and the different barriers they face in accessing services. Learning from the men and family relationship programs recognises that:

- When a man makes an initial contact with a program, the immediate environment and openness of staff towards him, will influence his level of engagement and trust. Most men enter new situations with suspicion about what will be expected of them and they rely on visual cues that suggest they can relax.[34]
- If there is a perceived power difference between men and the service providers, men will be more cautious and wary of engagement.
- Many organisations have found it useful to display positive posters. These posters are rich in Australian images of 'perceived equality' or close connection with important relationships, promote hope, health and well being.

A difficulty adult male victims face is the absence of material that directly speaks to men. This lack of sexual assault specific material increases the sense of isolation and the idea that 'there must be something particularly wrong about me, because it is women who are sexually assaulted not men'. Some men have reported that the only posters they see of men are those where men appear as the 'perpetrators' of abuse. LivingWell is the only service in Queensland that currently produces material designed to specifically assist men who have experienced sexual violence.

2. The existence of 'window periods' where men access support

The Working with Men Guide suggests that:

- For some men experiencing problems in their lives, there is a 'window period' during which they are more likely to access services for assistance. If men experience high levels of frustration and are unable to access services because of long waiting lists or complicated referral procedures, they are likely to give up trying and find other solutions to deal with their problems. These solutions frequently include ignoring the problem, or reacting in more aggressive ways.

A review of the Men and Family Relationship service found that additional barriers to men accessing services were:

- Not being well informed about what counselling involved.
- Believing that counselling does not 'work'.
- Feeling that existing services are really for women.

[34] King,A & Sweeney,S & Fletcher,R , "A checklist for organisations working with men", Developing Practice, Dec 2004.

- Feeling uncomfortable with the language and modes of communication traditionally used in counselling.

3. The need for men's services to be distinguished from general services

Experience in developing men and family relationship services suggests that:

- Programs for men need to have a strong branding about being male focussed. Unless the words male, men, dad, uncles, pops or fathers are used in the program title, they assume that the program is not relevant to them.


LivingWell's position is that designing a service that is 'men friendly' does not mean that it needs to be a 'men's only service', but that promotional material, the work space, and the design of service response is non-pathologising and is identified as 'inviting and relevant' for men.

4. The value of personal recommendation about services

It appears that:

- In the initial stages of operation, many men's programs experience low numbers of referrals and participants. In this start-up period, professionals need to persevere when the initial response by men to a program is not as high as anticipated. This is an experience that occurs in all community programs, however, when low client numbers occur in male focussed programs it is all too easily interpreted as an indicator of male disinterest.
- It is only after a period of time that programs develop a routine and consistency in service provision. This may include ongoing support groups, regular educational groups or even one-day workshops that are run every six months. It is the consistency over a long period, which builds a program's reputation as being effective and worthwhile.
- Many men will attend programs because of the recommendation of friends, mates or family members. Partners, friends and family members often become trusted advisors acting as a bridge to services, engaging with the service, finding out information and then attending with men to link them in.
- One of the strongest forms of marketing occurs when someone who a man trusts, recommends they should access a particular program. This referral is more effective when the client is given a direct telephone number and a specific name of a contact person at the service. Men may stop seeking help when they feel frustrated by their difficulties in contacting someone or accessing support.

In order to address some of the above difficulties LivingWell provides 'warm referrals' that reaches out to men and invites them to 'come and check out the service and counsellor'. At LivingWell it is quite common for a partner or family member to call to gather information and to support a man's attendance through attending couple counselling. An example of a recent facilitated referral is where a man attending Alcoholics Anonymous was supported by another attendee, who similarly experienced problem drinking and previously been subjected to sexual assault, to attend the LivingWell counselling service.

5. The importance of flexible service delivery

Evidence suggests that services seeking to assist men need to provide a range of programs and multiple entry points. It appears that men have a higher level of commitment when they can choose their level of involvement. Men's attendance at services is enhanced if there is:

- Individual and couple counselling,
- Counselling outside working hours.
- Evening programs.
- Support groups.
- Specialised programs for indigenous and culturally and linguistically diverse groups of men.
- Weekend events/workshops.
- Telephone counselling.
- Web services and email contact
- Internet blogs and support groups that deal with difficult issues.
- Gender specific, men friendly booklets and advertising material.

6. Client involvement in program development

Client consultation and involvement in development of suitable service delivery ensures that the programs stay relevant. Reference groups can provide important feedback about program direction, marketing, and provide ambassadors who can personally recommend the program to other men.

7. The solution focussed approach

Evidence from the Working with Men Guide is that:

- Men prefer a solution focussed activities and framework, and in particular adoption of a non-deficit approach. It is suggested that the solution focussed approach works well because it uses active solutions to current problems and involves practical tools.[35]

The evidence base in relation to effective counselling strategies when working with men who have been subjected to sexual violence is not large. Hence there is value in adopting an action research framework when designing and evaluating the most suitable counselling modalities for working with men in general, and with men from diverse populations. Evidence gleaned from trauma based research and therapy is that attention should be paid to the influence of gender in developing appropriate counselling services. John Briere states that:

> *"Although there is little doubt that men and women undergo many of the same traumatic events and suffer in many of the same ways, it is clear that (1) some traumas are more common in one sex than the other, and (2) sex role socialisation affects how such injuries are experienced and expressed. These differences, in*

[35] King, A 'Working with Men: The non-deficit perspective', Children Australia, Vol 25, No.3, 2000

> *turn have significant impact on the content and process of trauma-focussed therapy."*[36]

The KPMG Review noted that 'Work undertaken by the Institute of Family Studies has identified two treatment types that predominate in the literature', those being 'Cognitive therapies that seek to alter distorted cognitions' and 'Feminist group therapy approaches'. A difficulty in relying on this referred to report (Jill Astbury's article 'Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia'), is that its focus was on service responses to women. Although research suggests that cognitive therapies can help, the difficulty is that few approaches have been subjected to extensive or long-term evaluation with male survivors of sexual abuse. [37]

8. Local area coordination

The Working with Men Guide emphasizes the value in developing and maintaining state based support networks in order to share knowledge and learning. The lack of professional networks disseminating information and support for workers providing services to men, was highlighted in LivingWell's recent National survey of sexual assault services who identify as providing assistance to men.

Unfortunately, at present, as LivingWell is not funded by Queensland Health it is excluded from participating within the Queensland Sexual Assault Network (QSAN) as it is currently configured.


Although the KPMG Review emphasizes the need for local area coordination within Health Districts it does not articulate how information, evidence based practice, and resources in relation to working with men might be developed and disseminated throughout the State?


From reading the KPMG Review it is unclear how the 'New Way of Responding' will integrate with and compliment the proposed National Men's Health Strategy, and build on the learning from the Commonwealth Government guide for working with men.

Designing a response to meet the diverse groups of men

In the section detailing 'Best practice elements of a contemporary response' the KPMG Review identified that:

> *'As services have developed and evolved, it has been increasingly recognised that not all victim sub-groups have been able to access sexual assault programs and services to the same extent. The needs of male victims, children, victims from indigenous and other culturally and linguistically diverse backgrounds, those from*

[36] Briere J. and Scott C. 'Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Sage Publication: Thousand Oaks, California. 2006:78.

[37] Price, J. L., Hilsenroth, M. J., Petretic-Jackson, P. A., and Bonge, D. "A review of individual psychotherapy outcomes for adult survivors of childhood sexual abuse". Clinical Psychology Review, 21(7), 2001:1095–1121.

> *rural and remote communities and adults who have suffered historical abuse, have all become the focus of more dedicated thinking. Service providers should be aware of and plan around the barriers to accessing services that some groups of clients may experience.'(KPMG,2009:36)*

In the National Men's Health Policy Discussion Paper it is emphasised that 'Men in Australia are not one homogenous group, but consist of a wide variety of men across different age groups, different cultural groups, sexual preference and socio-economic status'. It is recognised that neither men nor women can be readily understood as a homogenous mass.

> *Epidemiological findings consistently reveal that the overall disease burden on men is not spread across all sectors of society, but rather disproportionately falls on some sections of the men's population. The use of aggregated data and averaging often conceals the fact that it is some groups of men who bear the heaviest burden of poor health.*[38]

In developing a service for men the KPMG Review, The National Men's Health Policy Paper and the National "Working with Men Guide all emphasise the need to be aware of and to respond to the particular needs of different groups of men. This is true of men who have experienced childhood sexual abuse or sexual assault, just as it is true of women.

Indigenous victims

'While prevalence rates are higher in Indigenous populations, reporting of sexual assault by Indigenous victims tends to be lower due to problematic relationships between Indigenous people and police, and a general lack of culturally appropriate responses' (2009:38).

The KPMG Review highlights both the 'under reporting' of sexual assault by Indigenous people and the 'lack of culturally appropriate responses' and draws attention to the value of employing indigenous women in mainstream sexual assault services. Currently Queensland Health funds Murrigunyah, to provide support to Aboriginal and Torres Strait Islander women and children who have experienced childhood sexual abuse or sexual assault. In designing a 'culturally appropriate response' it will be important to create a response that is appropriate for both Indigenous men and women.

The recent *Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred"* Report both emphasised the serious problem of sexual abuse within the Indigenous community and compounded problems for Indigenous men in further stigmatising them as potential perpetrators of abuse. In responding to Indigenous men who have experienced childhood sexual abuse or sexual assault it is important to recognise the Indigenous men's over representation in relation to poor health outcomes, including risk of suicide, drink and drug abuse. The 'Promoting Good Practice in Suicide Prevention: Activities Targeting Men' highlights the fact that young Aboriginal and Torres Strait Islander males are more likely than any other young Australians to die by suicide and that suicide rates are 40% higher in

[38] Department of Health and Ageing. National Men's Health Policy: Information Paper 2009.

Indigenous communities than the Australian population as a whole.[39] The report suggests specific strategies be developed to work with Indigenous men.

The National Health and Medical Research Council in its "Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder' acknowledges that a challenge in designing appropriate service responses is that there is very little evidenced based research to inform practice (there have been no trials to date to investigate efficacy of any treatments of PTSD in Indigenous people). The Guidelines emphasize that the magnitude of the problem of trauma in the Indigenous community is potentially overwhelming for individual practitioners and services. It identifies a need for a commitment to long term therapeutic work in collaboration with Aboriginal and Torres Strait Islander people, considering age, seniority and gender in determining who provides treatment to whom and under what circumstances. In responding to Indigenous people the 'Guidelines' identify a need to attend to people's current life circumstances and to ensure there is appropriate support and supervision of practitioners. [40]

Research indicates that effective engagement with Indigenous clients involves valuing and linking in with the expertise of Indigenous people. Aboriginal Elder Ray McMinn interviewed for the Working with Men and Family Relationships Guide (2009) states that interventions need to involve both elders and young males, to work alongside culturally competent staff in developing and maintaining services that are culturally appropriate.[41]

 In the KPMG Review it is unclear how the needs of Aboriginal and Torres Strait Islander men who have experienced childhood sexual abuse or sexual assault will be responded to throughout Queensland?

Victims from culturally and linguistically diverse backgrounds

The KPMG review recognizes the high needs and unmet service delivery to victims from culturally and linguistically diverse communities as a significant "victim sub group" (2009:39).

The report highlights the additional cultural and linguistic barriers to people from CALD backgrounds accessing services. Currently Queensland Health funds a sexual assault specific program through the Immigrant Women's Support Service providing referral and assistance to women and children. Although Crome (2006) discusses how established agencies might re-design service delivery to include men from CALD backgrounds as a type of "value added extra" service, it is generally accepted that men from Non English

[39] Department of Health & Ageing, 'Promoting Good Practice in Suicide Prevention: Activities Targeting Men' Life is for Everyone Publication: 2008.

[40]Australian Government, National Health and Medical Research Council, "Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder". 2007:136

[41]Department of Families, Housing, Community Services and Indigenous Affairs "Once were Hunters and Gatherers-Working with Aboriginal and Torres Strait Islander Men" in Introduction to Working with Men and Family Relationships Guide, Commonwealth of Australia, 2009.

Speaking Backgrounds would have great difficulty in disclosing sexual assault to services that are specifically designed for women, or may appear to be ambiguous about receiving men as clients.[42] The challenges in responding appropriately is not just in relation to encouraging disclosure but in designing a suitable 'victim centred' response. Difficulties can exist not only in relation to disclosure. Grossman, Sorsoli, and Kia-Keating (2006) research suggests that men's experiences and meaning making as victims of childhood sexual abuse or assault were influenced by ethnicity and that men of colour are less likely to access trauma focused therapy.[43]

When seeking to design a service specifically to respond to men from diverse communities who have experienced sexual assault attention is drawn to the social context of such abuse and the meaning making around it. If a man is a refugee or migrant client he might have experienced:

- Sexual assault occurring as an aspect of deliberate torture, accompanied by the witnessing of beatings and or the death of family and community members.
- Lengthy immigration experiences often over several years duration, and involving lengthy periods of temporary detention
- Disruption to family relationships eg loss of the support of parents, children, community
- Changing dynamics of authority and power between generations and opportunities for support
- Disappointment of expectations, lack of recognition of education qualifications and work experience
- Sense of loss of connection, loss of identity.
- Isolation, depression, loss of hope
- racism. [44]

 While identifying general needs for CALD clients the KPMG review does not articulate how the specific needs of men from CALD backgrounds will be considered and responded in service delivery throughout the state?

Gay, lesbian, bisexual and transgender people

In articulating 'Best Practice Elements of Contemporary Responses' The KPMG Review included lesbian, gay, bi-sexual and transgender people as amongst those who experienced greater barriers in accessing services. In so doing, the review identified 2.5%

[42] Crome, S. "Male Survivors of Sexual Assault and Rape" Australiaa Centre for the Study of Sexual Assault No 2, Sept 2006.

[43] Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: Meaning making by male survivors of childhood sexual abuse. American Journal of Orthopsychiatry, 76(4), 434–443. Grossman, F.K., Sorosli, L. & Kia-Keating M. 'I keep that hush hush: Male survivors of sexual abuse and the challenges of disclosure'. Journal of counselling psychology Vol. 55, No 3 333-345 (2008).

[44] Department of Families, Housing, Community Services and Indigenous Affairs 'Effective engagement of CALD men' in The Introduction to Working with men and Family Relationships Guide Commonwealth of Australia 2009:63-69. See also Queensland Program of Assistance for Survivors of Torture and Trauma.

- 4% of gay men and lesbians and 10-11.5% of transgender people in Australia having been sexually assaulted or raped, however, it is relevant to note that national and international studies suggest much higher prevalence rates. In the Australian *Private Lives* survey 19.6% of gay identifying men reported being forced to have sex by their partner. The New Zealand study '*Sexual coercion amongst gay men*', identified 11 International studies completed over the past 15 years that reported rates of sexual coercion amongst men who have sex with men ranging from 20.3% to 51%. [45]

The fact is that gay men, bisexual men, transgender men and men who have sex with men report significantly higher rates of sexual assault both as children and adults than the straight male population. For gay and bisexual men, as well as men who have sex with men, institutional heterosexism becomes a barrier that will often inhibit reporting of all except the most extreme cases of sexual assault.[46] Those who do report assaults may, if possible, conceal their sexuality.[47] Gay and bisexual men also report difficulties in disclosing their experiences of sexual coercion and assault to friends and family. For some, disclosing may necessitate 'coming out'. In some instances remaining silent and dealing with the accompanying difficulties may be preferable to the identity and relational implications of 'coming out'.[48]

In designing a service response to men it is important to recognize that:

- Men who have been subjected to childhood sexual abuse or sexual assault, whether identifying as gay or straight, are constrained by questions around sexuality and sexual relations.
- There is a need for service provision that does not collapse sex, gender and sexuality and understands the complexities of gender and sexual relations.
- Workers require knowledge in relation to how sex, gender and sexuality shape peoples lives and the way that gay and queer communities are positioned and configured.
- Services confront the dilemma of needing to be pro-actively gay and queer friendly, whilst not excluding those men who identify as overtly homophobic.

The report into 'Sexual coercion amongst gay men' highlights that:

> *The marginalisation of gay men in a heterosexist society contributes to the silence around men's experiences of sexual coercion in more ways than one. Gay men are already frequently labelled as 'predatory' and …that bringing to light stories of gay men being coerced into sex by other gay men risks confirming this stereotype. For a community that is already marginalised, this is potentially problematic. We are very mindful of the delicate political balance that is faced in raising issues*

[45] Pitts M. et al. Private Lives: A report on the health and well being of GLBTI Australians. Australian research centre in sex, health and society, LA Trobe University, Melbourne: March 2006.
Fenaughty, J. et al. Sexual coercion among gay men, bisexual men and Takatāpui Tāne in Aotearoa/New Zealand. University of Auckland, Auckland: August 2006.

[46] Davies, M. "Male Sexual Assault Victims: A Selective Review of the Literature and Implications for Support Services," Aggression and Violent Behaviour 7 (2002): 203-214.

[47] Hodge, Samantha, and David Canter. "Victims and Perpetrators of Male Sexual Assault," Journal of Interpersonal Violence 13, no 2, 1998: 222-239.

[48] Schwarzkoff, J. Wilczynski A. Ross S, Smith J & Mason G. 'You shouldn't have to hide to be safe – Homophobic hostilities and violence against gay men and lesbians in NSW', prepared for the Crime Prevention Division, NSW Justice and Attorney General's Department, Sydney, 2003.

> *such as this — discussing such aspects of a community whose members remain oppressed and disadvantaged to varying degrees within western societies opens up the risk of further discrimination.*
>
> *However, many of the forms of sexual coercion discussed in this report are acts that may be experienced as violating, distressing, and traumatic, in various ways, for the men involved. They can also be experiences that threaten a man's ability to avoid unsafe sexual practices. It is therefore important that space be opened within (and beyond) gay communities for acknowledgement, and candid discussion, of the issue of sexual coercion among gay, bisexual, and other men who have sex with men.*

To date, Queensland Association of Healthy Communities has been active in developing resources that specifically assist gay, lesbian, bi-sexual, transgender and queer community. In developing a way forward that specifically addresses the needs of the LGBT community it will be important to consult and link in with QaHC.

 The KPMG Review in detailing Best Practice Elements of a Contemporary Service response identified LGBT community as a specific 'victim sub group' requiring special consideration. However, it is unclear from reading the articulated New Way of Responding how the specific needs of the LGBT community will be considered and responded to?

Rural and remote victims;

The KPMG Review highlights the difficulties in reporting and accessing service that confront people from rural and regional communities (2009:42). Men, like women, in rural communities who have experienced sexual violence face additional concerns around privacy and confidentiality. Unfortunately, choice as to the gender, age, linguistic and cultural background and location of forensic nurse practitioners, social workers and counselors is also more limited in rural and remote areas.[49] In designing a service response to assist men who have experienced sexual violence it should be recognized that men in rural and remote communities are subject to poorer health outcomes and higher rates of suicide than men from metropolitan areas. Although new technologies such as the internet, email, telephone counselling and conference calls provide some access to information and support that was previously unattainable, this does not negate the need for local community services able to respond to the specific needs of men subjected to sexual violence.

 It is unclear from the review how, the gender specific needs of women and men who have experienced sexual violence and who live in rural and remote Queensland, will be addressed in a coordinated way? It will require some dedicated creative thinking and

[49] Monique Keel, "Sexual Assault and Mental Health in Australia: Collaborative responses for complex needs" in ACSSA Newsletter No 6 April 2005. Neame &Heeman, "Responding to Sexual Assault in Rural Communities", Briefing Paper No.3 June 2004, ACSSA, Australian Institute of Family Studies.

funding support if sexual assault is not to become an experience that increases disadvantage between men and women residing in metropolitan Queensland and men and women living in rural and remote Queensland.

Males with a Disability

The KPMG Review noted that 20% of sexual assault service users in Australia have a disability of some sort (KPMG 2009:42). The Review recognizes the potential under-reporting of sexual assaults on women with disabilities, especially those with intellectual or cognitive impairments, as being approximately twice that of the general population. Few studies or statistical analyses have been undertaken worldwide into the high numbers of people with a disability who become victims of sexual crimes. However what there is tells us that:-

- Among adults who are developmentally disabled, as many as 83% of females and 32% of males are the victims of sexual assault.
- 49% of people with developmental disabilities who are victims of sexual violence will experience 10 or more abusive incidents and over a much longer time frame than non-disabled victims.

In Queensland, to date, counselling support has only been offered to women with disabilities through WWILD (though WWILD through funding from the Department of Justice and Attorney General provides support to men with disabilities who are going through the legal process).

When responding to people with disabilities some consideration should be given to:

- Disabled people have many more dependent, long-term personal relationships especially if they live in an institutional setting. Because of their increased exposure to potential abuse in various care settings and their dependence on others, disabled people are at far greater risk and are far more likely to be assaulted than non-disabled people by persons that they know.
- Disabled people are also vulnerable to threats and abuse that is specific to their disability e.g. the use of restraints, medication, reduced hygiene care, food or mobility. Sexual abuse often occurs when sexual activity is demanded in return for assistance. These types of coercive and punitive strategies are rarely recognized by others as occurring within a violent context.
- Similarly it can be extremely difficult for disabled people to report these strategies as abusive and non-consensual when they may appear to be "going along with it". And it can be even more difficult to prosecute a case when the person committing the abuse is not someone who is intellectually disabled and claims that consent was given. This has strong implications for acute sexual assault services in understanding the nature of the assault following a presentation, the issue of consent to forensic, medical and legal services which may follow, and the relationship of any support persons in attendance.[50]

[50] Sobsey, D. "Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?. 1994. Valenti-Heim, D., Schwartz, L. 'The Sexual Abuse Interview for Those with Developmental Disabilities" 1995. Wisconsin Coalitiona Against Sexual Assault "People with Disabilities and Sexual Assault", Info Sheet Series 2003 www.wcasa.org. Gary, B., "Physical Abuse and Disabled People" American Association for Intellectual and Developmental Disabilities. Articles supplied by S. Seymour 'Victims of Crime - Disability Training Program', WWILD

While there are some sexual assault specific services such as WWILD that already provide counselling support to women with disabilities who have been subjected to sexual assault, it is unclear from the KPMG Review how the specific needs of men who have disabilities will be recognized and appropriately responded to throughout Queensland?

Males with a Mental illness

The KPMG review identifies people with a mental illness as a client group who have specific sexual assault service support needs (2009:42). International research indicates that the experience of sexual assault has a high correlation with severe mental illness in both men and in women. A survey by the Sexual Assault Resource Centre in Western Australia (2004) found that 54.8 per cent of people attending the centre (following a recent assault or because of past sexual abuse) had been diagnosed with a mental health disorder and 20.6 per cent experienced drug and/or alcohol problems. Of those who had experienced sexual assault both as children and adults, 71.0 per cent had a mental health or substance abuse problem. A picture of the negative health outcomes that men subjected to sexual violence can experience is painted by a recent Australian study:

- 17.2% of community men qualify for a clinical diagnosis compared to *65.8% of men who were sexually abused as children.*
- Men who were sexually abused as children were 10 times more likely to qualify for a diagnosis of PTSD (post-traumatic stress disorder).
- Men who were sexually abused as children were 5 times more likely to engage in alcohol and drug abuse
- Men who were sexually abused as children were 10 times more likely to report suicidal ideation
- 46% of CSA men had attempted suicide at sometime.[51]

The 'cost' in health outcomes of sexual assault of men highlights a need to be pro-active in developing relevant service responses for men that intersect with mental health services. A targeted service response will be able to build upon recent research that identified the greatest predictors of male victims of sexual assault engaging in suicidal ideation are 'feeling isolated and alone, acting violently and aggressively, blaming themselves for the abuse occurring, feeling fearful, anxious or confused and usage of alcohol and drugs'.[52] When it is considered that between 1994 and 2004 men accounted for 80% of the deaths by suicide in Australia and that men who have experienced childhood sexual abuse report such a high level of suicide attempts it is problematic that the excellent document 'Promoting Good Practice in Suicide Prevention: Activities Targeting Men' Life is for Everyone Publication 2008 does not have a section detailing how best to respond to men who have been subjected to sexual violence. In developing a response to men who experience mental illness it may also be possible to learn from the Victorian Government Document 'Building partnerships between mental health, family violence and

[51] O'Leary, P. 'Men were sexually abused as children'. Doctoral Thesis, Flinders University, South Australia 2003.

[52] O'Leary, P., & Gould, N. 'Men who were Sexually Abused in Childhood and Subsequent Suicidal Ideation: Community Comparison Explanations and Practice Implications', Journal of British Social Work, 39, 2009:950-968:14.

sexual assault services' which, although women centred, highlighted a need for integrated and co-ordinated service response across government departments.[53]


Whereas the KPMG review did identify people with mental illness as a specific victim "sub-groups" deserving of a focused response, it is unclear how in a 'New Way of Responding' how the specific needs will be responded to in a coordinated and purposeful manner?

Male victims in institutional settings

The KPMG Review identifies victims in institutional settings as a victim sub group that deserves special consideration, stating that 'sexual abuse of men in prisons and custodial facilities is well established' and that official statistics do not reflect 'the true rate of these crimes' (2009:43). The need for specific service responses for people who are sexually assaulted in Institutional settings, both in 'prisons', 'Inpatient Mental Health Services' and 'homes' has been the focus of some research and government attention.

The most extensive research of sexual assault in prisoners undertaken in Australia to date identified that 25% of 18-25 year olds in the prison population were being sexually assaulted whilst incarcerated.[54] Although the KPMG Review does not make reference to it, in Queensland, the Department of Corrective Services does acknowledge that sexual assault happens in prison and has policies and procedures to make prisoners aware of the ever present danger and their responsibility to report it. In seeking to respond appropriately QDCS policy directs that:

> Any prisoner who makes an allegation of sexual assault must be referred to a Senior Psychologist/Psychologist within 24 hours…The psychologist must assess the prisoner's level of post-assault trauma and, with prisoner consent, immediately implement a debriefing and treatment plan. The initial assessment must include an At-risk assessment.[55]

However, there are very significant barriers that exist to reporting or disclosing sexual assault while in institutions whether these are prisons, detention and rehabilitation centers, psychiatric hospitals, or in residential care homes. In designing a response it should be recognized that disclosure is a complex process influenced by the situational context and that there are very good reasons for the non-disclosure of sexual assaults within the institutional context, chiefly amongst these is the realistic fear of retribution.


Although, in the section that details best practice considerations the KPMG Review highlights 'risk factors', that increase likelihood of sexual assault in prisons - 'men who

[53] Victorian Government Department of Human Services, 'Building partnerships between mental health, family violence and sexual assault services – Project report, Melbourne, Victoria (2006). See also Monique Keel "Sexual Assault and Mental Health in Australia: Collaborative responses for complex needs' ACSSA Newsletter No 6 April, 2005. Hidday, V.A., Swartz, M., Swanson, J., Borum, R., and Wagner, H.R. "Criminal Victimization of Persons with Severe Mental Illness." Psychiatric Services 50: 1999: 62-68. Department of Health and Ageing 'Living is for Everyone: Research and Evidence in Suicide Prevention' Australian Government: 2008:34-35.

[54] Heilpern, David M. Fear or Favour: Sexual Assault of Young Prisoners. Lismore: Southern Cross University Press, 1998.

[55] Queensland Department of Corrective Services DCS, "Procedure – Offender Management: Sexual Assault", 2.

have sex with men, inter-racial violence; and history of childhood sexual abuse' – it does not articulate how the 'new way of responding' through the co-located hubs will provide a service to this group of men?

 In addition, the KPMG Review does not identify how the 'new way of responding' links in with Queensland Health's own policy document 'responding to sexual assault and promoting sexual safety within Inpatient Mental Health Services' and with the After Care Resource Centre funded by the Department of Communities, to provide counselling and support to people, living anywhere in Australia who experienced abuse as children whilst living in church or government institutions, detention centres or foster care in Queensland?

Young Males

Whilst the KPMG Review did not emphasise a need to design appropriate service responses to engage support and assist young people, it has been highlighted elsewhere. The Victorian Standards of Practice for Centres Against Sexual Assault emphasise the specific service delivery concerns in relation to 'Crisis Care and Counselling Issues in Working with Young People' in a way that recognises that young people have individual and diverse needs.[56] In the UK evaluation of 'Sexual Assault Referral Centres: developing good practice and maximising potentials' the 'Start Young Persons Project was identified as part of an evolving best practice response. In seeking to reach out and engage young people, 'The Havens' have developed youth friendly services and resources, such as the booklet -'Coping with sexual assault: A guide for young people'. In Brisbane, Zig Zag Young Women's Resource Centre has for over 20 years provided direct service to young women who have experienced sexual assault and is currently funded by Queensland Health (recognising that women in the 18-24 age group are most at risk of sexual assault - Women's Safety Survey 1995). In liaising with Zig Zag, LivingWell has provided some assistance to male partners, siblings and family members of young women.

In seeking to develop a relevant service model to assist all Queenslanders it is useful to note that the World Health Organization has called for the development of youth friendly services that actively work to improve young people's access to health services. Supporting the call for specific youth friendly service, recent research has emphasized the need for sensitive services that recognize and support young people's unique stage of biological, cognitive, and psychosocial transition into adulthood.[57] Examination of help-seeking behavior indicates that young people are less willing to disclose sensitive issues (like sexual assault or childhood abuse) and turn more readily to peers, or to family members for assistance. Suggestions are that youth based services are most effective when they are:-

[56] Victorian Department of Human Services, 'Standards of practice for victorian centres against sexual assault.' 2000:63-69

[57] A Tylee, DM Haller, T Graham, R Churchill, LA Sanci "Youth-friendly primary –care services: How are we doing and what more needs to be done?" The Lancet Vol.369, Issue 9572, 2007: 1565-1573.

Visible	offering a range of services directed specifically to youth
Low cost	seen to be affordable
Convenient	to schools, workplaces, universities
Accessible	to public transport
Confidential	especially in relation to parents and guardians
Private	in waiting areas and around entry points
Flexible	hours of opening, nights, early mornings and weekends
Non-judgmental	in service delivery
Informative and supportive	

The National Men's Health discussion paper has also highlighted how service need to be adapted to become accessible to young males and that specific strategies are required to address the behaviour of young males that lead to their over representation in relation to transport accidents, workplace accidents, suicide, injury, skin cancer, accidental poisoning, STIs, sexual identity/ gender diversity, alcohol, risky behaviour, tobacco and recreational drug use and the impact of homophobia.

 Given that the KPMG Review did not identify young people or young males as a particular 'victim sub group' requiring assistance, it not clear how services will be adapted to become youth friendly and meet the specific needs of young males and females who have experience sexual assault?

Male sex workers

The KPMG report does not specifically recognize the high needs and unmet service delivery of male sex workers. However, previously in National government reports 'sex workers' have been identified as a group that experienced greater incidence of sexual assault than the broader community and deserving of special assistance.[58] In designing a service response to male sex workers as a victim group particularly vulnerable to sexual assault, it may be useful to consult with sexual health clinics and workers and to recognize that male sex workers experience:

- Concern in relation to confidentiality and privacy
- Fear of staff bias and negative attitudes, especially if identifying as gay or transgender
- Anxiety about moral judgment of staff
- Wish for choice of gender in practitioner
- Complex issues mixing of childhood sexual assault, psychological, mental health issues
- Drug and alcohol problems concurrent
- Transient lifestyle - making contact/counseling difficult and inconsistent,

[58] Office of the status of women, National framework for sexual assault prevention. Commonwealth Government 2004.

- Accommodation needs
- Risk taking, self-harming, suicidality[59]

Partners, friends and family member of males who have experienced child hood sexual abuse or sexual assault

Whereas Queensland Health has a history of acknowledging the important role partners, family and friends play in supporting people who have experienced sexual violence, the KPMG Review does not provide details of how this 'support and information for partners, friends and families' might be integrated into the new way of responding (2009:54). It is recognized that partners, family and friends in providing support and understanding can play a significant role in ameliorating the impact of sexual violence and that often they require support in carrying out this role. Both Lievore (2005) and Morrison (2007) identify how the extent to which a person is affected can be shaped by the reactions of partners, spouses and family members.[60] The 'social support' of family members and the need to 'support the supporters' is particularly relevant given that disclosure is typically made to partners, friends, and family members prior to professional services and many 'survivors' of sexual assault will never access professional counselling and support.[61]

A difficulty for men is that research suggests that men are less likely than women to receive the positive 'social support' of family, friends and partners.[62] Whilst much research has focused on social support of women, David Denborough in talking about the dynamic impact of the sexual violence of men, notes how sexual assault produces 'ripple effects' throughout men's lives that flow on into the lives and relationships of partners, family and friends.[63] Jim Hopper PhD on his influential web site providing information in relation to the sexual assault of males highlights:

> - Need to assist those whose "loved ones" have experienced abuse or assault to "sort through" their own feelings, fears,, frustrations, thoughts and ideas on how best to assist and take care of themselves in the process.[64]

Given the role that partners, friends and family play in supporting men's health and well being, it becomes especially important that comprehensive information and support is provided in an integrated and coordinated way, building community capacity to respond appropriately.

---

[59] McMullen, Richie J. Male Rape: Breaking the Silence on the Last Taboo. London: The Gay Men's Press, 1990.

[60] Lievore, D. 'No longer silence: A study of women's help-seeking decisions and service resoponses to sexual assault'. A report prepared by the Australian Institute of Criminology for the Australian Government. Department of Families, Housing, Community Services and Indigenous Affairs Office for Women 2005. Zoe Morrison, "Caring About Sexual Assault" in Family Matters, Australian Institute of Family Studies, No 76. 2007:55-63.

[61] Breckenridge J., Cunningham, J. and Jennings K. 'Cry for help: Client and worker experiences of disclosure and help seeking regarding child sexual abuse'. Australian Institute of Social Relations and The University of New South Wales, 2008:35

[62] Washington P. The Second Assault of Male Survivors of Sexual Assault, Journal of Interpersonal Violence. 1999.

[63] David Denborough, interview with Cameron Boyd 'Preventing Prisoner Rape' (SA) ACSSA Newsletter No. 14, June 2007.

[64] Hopper, J. PhD 'Resources for Spouses, Partners, Friends' in Child Abuse Statistics, Research, and Resources for Recovery, www.jimhopper.com.

In the South Australian 'Cry of help' report a specific recommendation was made that advice and support be provided to significant adults and family members, including counselling. At LivingWell, a significant aspect of service delivery in relation to men is the provision of support to the supporters in the form of counselling and informative material. The 'phasal' aspect of the impact of sexual violence means that it is often in longer term relationships that difficulties appear and therefore the provision of sensitive couple and family counselling is an important part of service delivery.


The KPMG Review has not focussed on the important role of community capacity building to enhance people's 'social support' networks. Given that the response of partners, friend and family members has been shown to both ameliorate or compound difficulties for people who have experienced sexual violence, it will be important to design service responses that supports them and their endeavours.

State wide focus on prevention and community education

The KPMG Review recommendation of a state wide focus on prevention and community education is to be commended for its acknowledgement of a need to include information on 'recent assaults, childhood abuse and abuse of males'. (KPMG 2009:77). Although the development of effective, evidence based, whole of government prevention and education strategies has been a focus of recent research and government reports, to date, federal and state campaigns have been specifically directed at the serious problem of violence against women, (with $20 million allocated to the 'Australia says not to violence against women').[65] The *National Framework for Sexual Assault Prevention* specifically identifies a need to develop 'targeted' strategies directed at specific groups of victims/survivors, including men, in a way that reduces to the ongoing health costs of sexual assault.

A useful recent report that highlights the need for a highly developed gender analysis in designing effective prevention and community education strategies is the *Framing Best Practice: National Standards for the Primary Prevention of Sexual Assault through Education* report.[66] Another report that emphasises the value of community education is 'Cry for help', which recommended:

> *that a website be developed providing advice to community members and professional regarding disclosure and help seeking behaviours, and helpful responses to disclosure of CSA by a child, an adolescent or an adult.*[67]

[65] Michelle Davies, in detailing problems facing men draws attention to the unintended consequences of emphasising sexual assault as a crime against women: "Ironically…the publicity that rape has received as a feminist issue has contributed to the isolation experienced by male victims of sexual assault" - Davies, M. "Male Sexual Assault Victims: A Selective Review of the Literature and Implications for Support Services," Aggression and Violent Behaviour 7 (2002): 203-214.

[66] Carmody, M. National Sexual Assault Prevention Education Project (SAPE) Framing Best Practice: National Standards for the Primary Prevention of Sexual Assault through Education, 2009. Recent International campaigns, such as 'My Strength is not for Hurting' and 'Consent is Sexy', may also provide some guidance as to the relevance and effectiveness of such strategies, even though they predominantly focus on heterosexual rape.

[67] Breckenridge J., Cunningham, J. and Jennings K. 'Cry for help: Client and worker experiences of disclosure and help seeking regarding child sexual abuse'. Australian Institute of Social Relations and The University of New South Wales, 2008.

To date, there has been development of some resources specifically targeted at men. In New South Wales, ECAV has for over a decade produced the excellent documents 'Who can a man tell' and 'When a man is raped'. Although, the LivingWell service and web resource is already designing and distributing material to raise awareness of sexual assault of males, this does not negate a need to develop an integrated and coordinated state wide prevention and education strategy for males and females who have been sexually victimised and for their supporters.

 Although the KPMG highlights the importance of prevention and community education strategies it is unclear what the 'next steps' are to ensure their implementation and how they will directly assist men who have been experienced sexual assault, given there is a lack of current research material to draw upon?

Research and data collection

The need for ongoing research is highlighted within the KPMG Review. The Review suggests a need to develop ongoing relationships with Universities and Hospitals, to develop and maintain relationships across jurisdictions that ensure currency in policy and practice outputs and to develop conference and academic papers that ensures linkages with sexual assault services (KPMG 2009:88). The need to develop a comprehensive research driven evidence for working with men is significant, given that, in 2002 it was "estimated that research, help, and support for male victims is more than 20 years behind that of female victims".[68] Banyard et al (2004), in outlining a way forward noted 'patterns of gender similarity and difference are important, and neither should be an exclusive focus of research questions' and further that there is a need to examine:

> *'more closely other background factors in the lives of CSA survivors that may help us understand links between CSA and more proximal adult outcomes for men, who have rarely been the subject of second and third generation studies, that have, to date, nearly exclusively focussed on female survivors. Such information is critical for designing appropriate services for male survivors that build on what we have learned from the experience of female survivors but also are tailored to unique aspects of men's experiences'.*[69]

Also, it is important to note that while there has been a rapid growth in evidence pertaining to certain clinical aspects of men's health and the status of men's health, there are still many gaps in knowledge. It is increasingly recognised that the type of population-wide changes needed to address problems associated with social context and lifestyles require the active engagement of a wide range of sectors and settings beyond health care. In many cases, effective strategies are underpinned by strong health social marketing programs, centred on evidence-based, targeted communication campaigns, which compliment focussed activities at the local level.

[68] Davies, M. "Male Sexual Assault Victims: A Selective Review of the Literature and Implications for Support Services," Aggression and Violent Behaviour 7 2002:204.

[69] Victoria Banyard, Linda Williams Jane A Siegel Childhood sexual abuse: A gender perspective on context and consequences' Child Maltreatment, Vol.9 No.3. August 2004:236

In 2009, LivingWell in conjunction with the University of Queensland conducted the first national survey of service responses to men who have experienced sexual violence. What is needed is to build the knowledge base of effective strategies for engaging and responding to men who have experienced childhood sexual abuse or sexual assault.


Whilst the KPMG Review advocates a need for quality research, it does not clearly articulate how this might be linked in with the sexual assault data collection framework in order to develop a research driven evidence base that supports service delivery?

Quality Training

The KPMG Review highlights a need for training and professional development that fits within a quality management, continuous improvement framework (KPMG 2009:2). The development of 'world class education and training' is also something the Queensland Government has identified as one of its five visions for all citizens towards 2020. LivingWell is aware that Sexual Assault Worker Training (SAWT) has recently been developed by Queensland Health and is due to be implemented to a limited degree in 2010. Whilst Living Well currently offers consultation, professional development and training workshops specifically aimed at 'Building worker confidence and competence in responding to men who have experienced childhood sexual abuse or sexual assault' it recognises a need for training that is integrated with, compliments and builds upon the SAWT recently developed by Queensland Health. In terms of community capacity building and sharing knowledge it may be that a range of training programs and resources, online and direct, will need to be developed and evaluated to meet the needs of different 'victim sub groups'.

The NSW Education Centre Against Violence currently offers 27 courses in relation to responding to sexual assault. ECAV provides specific training for working with men:

- Who can a man tell? — Working with men who have been sexually assaulted (3 Day Course)
- The Sexual Assault of Aboriginal Boys & Men: — (3 Day Workshop)

In NSW these courses are designed to be integrated with and compliment the established 'foundational' sexual assault worker training courses attended by all sexual assault service providers.


It is unclear from the KPMG Review how the necessary training for working with men who have been subjected to sexual violence will be developed, support, integrated and coordinated with the new Queensland Sexual Assault Worker Training?

Opportunity to address identified gaps in current service responses

The KPMG Review identifies clear gaps in current Queensland Health responses to 'male victims', commenting that '[t]his situation is untenable and must be addressed' (2009:70). In developing this limited response to the KPMG Review, Livingwell is aware that a lack of services for men who have experienced sexual violence has previously been identified in

Government documents, in internal reports and ministerial letters, without, to date, producing significant change.

In 2000, the Queensland Government Report Project Axis Child Sexual Abuse in Queensland: Responses to the Problem (2000), highlighted that there existed "Gaps in Service Provision", with a specific need "For services for male victims, both child victims and adult survivors".[70] In May 2007 Queensland Health area coordinators for Sexual Assault and Domestic and Family Violence undertook an internal mapping exercise that identified a need to introduce 'services that would more universally respond to male victims' (2009:59). In January 2008, in line with internal government reviews the previous year, Premier Anna Bligh acknowledged that:

> "there is a gap in service provision for males and that the current system needs to be reviewed to ensure equitable distribution and access across the State for both men and women."

In November 2008 the Victims of Crime Review Report by the Department of Justice and Attorney General again commented on a 'limited services for male sexual assault victims'.[71]

Whilst advocating in this document for the improvement of service responses to males who have been subjected to sexual violence, LivingWell welcomes opportunities to work collaboratively with Queensland Health, Government Departments, Non Government Organisations and the general community in developing integrated, coordinated, purposeful, accountable, effective best practice responses that assists all people who have experienced sexual assault.

As stated at the outset, this initial response by LivingWell to the KPMG Review of Queensland Health services to adult victims of sexual assault is tendered as part of the consultation process initiated by Queensland Health in November 2009. LivingWell welcomes this opportunity and any future opportunities to contribute to the development of improved services for all victims of sexual assault throughout Queensland.

[70] Queensland Crime Commission, 'Project Axis Vol. 2: Child sexual abuse in Queensland — responses to the problem'. 2000:100.

[71] Queensland Department of Justice and Attorney General, 'Victims of Crime Review Report' November 2008